

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04733 CERTIFICATE OF DEATH 04727									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
MILDRED			A			4 Month 30 Day 69 Year			1:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
FEMALE		WHITE		10-22-86			82 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			MEMORIAL HOSPITAL			Housekeeper			At Home
13a. USUAL RESIDENCE (Where deceased lived, if different from birthplace)			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER
BALTIMORE			ALLEGANY			CUMBERLAND			NO <input checked="" type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN SANDERS			EMILY WALTERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			217-05-3177			MEMORIAL HOSPITAL			CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>4123 Congestive heart failure</u>									6 months
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Astherosclerotic heart disease</u>									yes.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Pneumonia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>87</u> , to <u>4/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<u>Dr. G. Simons</u>					<u>5/1/87</u>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR. G. SIMONS					CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		5/3/69		Zion Memorial Park			Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service, Cumberland, Md				21502		MAY 5 1969		<u>Charles Judge</u>	

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Journal of Management Education 30(6)

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ST-1 - 3117 D. MEDICAL HOSPITAL, CINCINNATI, OH.

210112 2A 30

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04734 CERTIFICATE OF DEATH 04728									
1. DECEASED-NAME (Type or print) MABEL			First M. Middle M. Last BAER			2a. DATE OF DEATH APRIL Month 27 Day 69 Year			2b. HOUR 11:00 PM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-7-1900			6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MYERSDALE, PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			10. CITY OR TOWN OF DEATH CUMBERLAND
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER			12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PENNA.		13b. COUNTY MYERSDALE		13c. CITY OR TOWN MYERSDALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 122 BROADWAY	
14. FATHER'S NAME First C. Middle P. Last BAER			15. MOTHER'S MAIDEN NAME First MAGGIE Middle LIEBERKNIGHT Last LIEBERKNIGHT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 187-36-7988			17. INFORMANT PTS. HOSP. CHART			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 3471 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ATROPHY AND EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS			
19a. DATE OF OPERATION 4-22-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL ADHESIONS			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Kaufman			DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-28-69		
22d. PHYSICIAN'S NAME (Type) MATTHEW KAUFMAN, M.D.			22e. ADDRESS 912 SETON DRIVE CUMB., MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/30/1969		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery			23d. LOCATION (City or Town) (County) (State) Meysersdale Somerset Pa		
24. FUNERAL DIRECTOR Price Funeral Home 325 Main St Merle Ray Leckemby Meysersdale, Pa.					25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

04734

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WHITE

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MADE IN U.S.A.

USA

ALLEGY

CUMBERLAND

SACRED HEART HOSPITAL

TEACHER

FLORIDA

PERIOD

WYERSVILLE

122 DOWNEY

C.

H.

DEER

MAGGIE

LIEBERKNIGHT

NO

1-7-30-7-1000 THE H.S. CHART

CUMBERLAND, NO. 2102
900 SEVEN WHITE
SACRED HEART HOSPITAL

WALTER KALMAN, N.Y. 912 SEVEN DRIVE CHART, NO. 2102

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04735

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04729

1. DECEASED-NAME (Type or Print)			First Toleda			Middle Mae			Last Bennett			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b. HOUR 8:45 P M								
3. SEX Female			4. RACE White			5. DATE OF BIRTH 6/14/1892			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>			IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>			2d. HOUR 9:45 P M		
7a. BIRTHPLACE (State or foreign country) Penna			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany			Md.											
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Flintstone			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER											
14. FATHER'S NAME Michael			First Michael			Middle Northcraft			Last Leona			15. MOTHER'S MAIDEN NAME Wilson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-10-6634D			17. INFORMANT Alvin H. Bennett			ADDRESS 26767 Wiley Ford, W. Va											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden -----																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED April 10, 1969											
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ADDRESS 21502			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/13/69			23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery			23d. LOCATION (City or Town) (County) (State) Chaneyville Bedford Penna														
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md			ADDRESS 21502			25a. REC'D BY REGISTRAR APR 15 1969			25b. REGISTRAR'S SIGNATURE [Signature]														

05735

MILITARY SERVICE RECORD OF DEATH

DEATH IN THE LINE OF DUTY

UNITED STATES ARMY

NAME		LAST		FIRST		MIDDLE	
RANK		GRADE		CLASS		STATUS	
BRANCH		SERIAL		COMPONENT		DATE	
REGIMENT		COMPANY		PLATOON		SECTION	
BATTALION		SQUAD		TEAM		POSITION	
DIVISION		CORPS		ARMY		NATION	
THEATRE		ZONAL		ACTIVITY		DESCRIPTION	
COUNTRY		LOCALITY		COORDINATES		ELEVATION	
WEATHER		TEMPERATURE		HUMIDITY		WIND	
MOON		PHASE		TIMING		DURATION	
TIDE		HEIGHT		DIRECTION		VELOCITY	
CURRENT		SPEED		DEPTH		PRESSURE	
WAVE		PERIOD		WAVELENGTH		FREQUENCY	
SEA		STATE		WIND		WAVE	
CLIMATE		TEMPERATURE		HUMIDITY		WIND	
SOIL		TYPE		MOISTURE		TEMPERATURE	
ROCK		TYPE		HARDNESS		COLOR	
VEGETATION		TYPE		DENSITY		HEIGHT	
FAUNA		TYPE		DENSITY		HEIGHT	
FLORA		TYPE		DENSITY		HEIGHT	
MINERAL		TYPE		DENSITY		HEIGHT	
METEOR		TYPE		DENSITY		HEIGHT	
ASTEROID		TYPE		DENSITY		HEIGHT	
COMET		TYPE		DENSITY		HEIGHT	
PLANET		TYPE		DENSITY		HEIGHT	
SUN		TYPE		DENSITY		HEIGHT	
MOON		TYPE		DENSITY		HEIGHT	
STAR		TYPE		DENSITY		HEIGHT	
GALAXY		TYPE		DENSITY		HEIGHT	
UNIVERSE		TYPE		DENSITY		HEIGHT	

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VR A15 41
45M - 11 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04736

04730

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR MM					
BABY GIRL			BLACKER			APRIL 15 1969			11:45					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-15-69			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.				
1d. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			none			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
MD.		ALLEGANY		CUMBERLAND				10 HARRISON ST.						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
GARY L. BLACKER						JUDY M. HERSH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
no			none			MEMORIAL HOSP.			CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Failure of All Systems</u> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previsible Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Leland B. Ransom</u>						DEGREE ATTENDING PHYS.			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 18 April 69		
22d. PHYSICIAN'S NAME (Type) LELAND B. RANSOM, M.D.						22e. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Apr. 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.						
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE APR 21 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

04730

DATE 11-1-59 NAME GARY GIBB FLAG ER

4-15-59 FEMALE WHITE

ALLANY

none none MEMORIAL HOSPITAL

NO. ALLEGANY CO. 10 LABRISON ST.

GARY L. BLACKER JUDY

none none MEMORIAL HOSP.

HERST

CUMBERLAND, MD.

ALLANY

none none

HERST

CUMBERLAND, MD.

ALLANY

none none

HERST

CUMBERLAND, MD.

ALLANY

none none

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First JOHN			Middle R			Last BRINHAM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 12-10-1895			20. DATE OF DEATH Month Day Year APRIL 14 1969		
70. BIRTHPLACE (State or foreign country) GLENCOE, PA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DENTIST			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last MILLARD F BRINHAM			15. MOTHER'S MAIDEN NAME First Middle Last MALINDA WILMATH			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WWI			16b. SOCIAL SECURITY NO. 215-44-9048		
17. INFIRMARY Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant mixed Cell Thymic Carcinoma</u> <u>199.1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rejoin</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cervical mass - enlarged.</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , to <u>Apr. 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>Apr 13</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Carlton Brinsfield</u>			DEGREE ATTENDING PHYS.			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22c. DATE SIGNED <u>4-15-69</u>		
22d. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD			22e. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/16/69			23c. NAME OF CEMETERY OR CREMATORY Sunset Mem Park Mausoleum			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR ADDRESS Silcox-Merritt Funeral Service, Cumberland, Md			25a. REC'D BY REGISTRAR APR 18 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

04737

ATTENTION OF UNIT

JOHN Y. B. DEIRHAN 12-10-1942

WIFE 12-10-1942

CLEONE, PA. USA

QUEBEC, CANADA

ALICE Y. DEIRHAN 12-10-1942

WILLARD F. DEIRHAN 12-10-1942

12-10-1942

12-10-1942

12-10-1942

12-10-1942

12-10-1942

12-10-1942

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12-10-1942

12-10-1942

12-10-1942

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First FRANCIS		Middle E.		Last BRODE		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 4 - 16 - 1969			2b. HOUR 7:50 AM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH DEC. 15, 1912		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 16, 1969		2d. HOUR 7:50 AM	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY						Md	
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) ELEC. TRUCK OPERATOR				12b. KIND OF BUSINESS OR INDUSTRY CELANESE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY GARRETT		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 2			
14. FATHER'S NAME First Middle Last ADAM BRODE				15. MOTHER'S MAIDEN NAME First Middle Last CLARA MICHAELS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO. (If yes, list work dates of service) 214-07-3995		17. INFORMANT MRS. ANNA M. BRODE, RT. 2, BOX 463, FROSTBURG				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema, Marked DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 814.7 (b) Contusions of Brain DUE TO, OR AS A CONSEQUENCE OF (c) (Struck by auto)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 38 Hours 32 Hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 11:15 P.M. April 14, 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pedestrian struck by Auto							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. #220 at Celenese		21f. LOCATION Street or R.F.D. No. City or Town County State Cumberland, Allegany, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 16, 1969					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county) RD 9, CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APR. 18, 1969		23c. NAME OF CEMETERY OR CREMATORY BRODE CEMETERY				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.					
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. 21532						ADDRESS		25a. REC'D BY REGISTRAR DATE APR 22 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

04732

Respectfully

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04739		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04733			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
(JOHN) W. H. BUCHANAN						4 Month 8 Day 69 Year		11:15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		2-11-02		67 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		PRESIDENT		BUCHANAN LUMBER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
W. VA.		MINERAL		KEYSER				Carskadon Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT	
HOWARD		BUCHANAN		Address 903 SETON DR. CUMBERLAND, MD.		171-07-2202		HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREbro-VASCULAR ACCIDENT (THROMBOSIS)								12 DAYS	
4339 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-14-1959, to 4-8-1969, that (I) (we) last saw the deceased alive on 4-8-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTERAR	
R. W. BALLIN, MD.		4-9-69		62 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CRYPT		23d. LOCATION (City or Town) (County) (State)		23e. REGISTERAR'S SIGNATURE	
Burial		4/11/69		Rose Hill Mausoleum		Cumberland Allegany Maryland		APR 14 1969	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERV. CUMBERLAND, MD.		APR 14 1969		APR 14 1969		APR 14 1969			

00100

11:15

00

1

BUCHANAN

11:15

11:15

00

2-5-00

WHITE

MALE

ALLERGY

USA

WALLAND

BUCHANAN
LUNGER

PRESIDENT

SACRED HEART HOSPITAL

CUMBERLAND

X CUMBERLAND

KEYES

MINERAL

11:15

BUCHANAN

ELIZABETH

(HOOES)

BUCHANAN

HOWARD

900 SEVEN DR.
CUMBERLAND, MD.

HOSPITAL RECORDS

NO

2-5-00

GENERAL SURGEON (HOOES)

62 GREENE ST., CUMBERLAND, MD.

R. W. BOLLIN, MD.

FOR DECATON

CUMBERLAND, MD.

SIX-HEART FUNERAL SERV.

04740

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
WALTER		W.		BURKETT	4 Month 29 Day 69 Year		5:45A		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		7-15-1909		59 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PA.	USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		Celanese employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
PA.		Bedford		HYNDMAN				MILL ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
SIMON				BURKETT	BERTHA				GARDNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		208-03-2187		MEMORIAL HOSPITAL,		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Esophageal Variceal Hemorrhage 24 hrs									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Cirrhosis, Nutritional								10 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Multiple Myeloma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 29th, 1969, that (I) (we) last saw the deceased alive on 29th, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
DR. MILTENBERGER									
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 2, 1969		Madley Cemetery		Buffalo Mills, Pa. RD#1			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Harvey H. Feigler				Hyndman, Pa. 155		MAY 5 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

047601

WALTER

BURKETT

WHITE

MALE

1-1-10

ALLERBY

PA.

CONNECTION

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

ARMY

ST. CITY

ARMY

GARTNER

204-03-1111 CENTRAL HOSPITAL, CONNECTICUT, CT.

DR. WILSON

CONNECTICUT, CT.

1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04741									
CERTIFICATE OF DEATH									
04735									
1. DECEASED-NAME (Type or print) WILLIAM J. COLEMAN					2a. DATE OF DEATH APRIL Month 3 Day 1969			2b. HOUR 3:55A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-8-07		6. AGE (In years as birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Retired Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 601 OLDTOWN RD.	
14. FATHER'S NAME First Middle Last JOSEPH COLEMAN			15. MOTHER'S MAIDEN NAME First Middle Last ANNA DECKER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-05-6272		17. INFORMANT Address MEMORIAL HOSP., CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, due to Lower Nephron Nephrosis months DUE TO, OR AS A CONSEQUENCE OF Anemia due to Hypoproteinemia, due to (b) Rheumatoid Arthritis, Toxic Hepatitis, with DUE TO, OR AS A CONSEQUENCE OF Cirrhosis of Liver; Anascara, with (c) Refractory Heart Failure; Ulcerative Colitis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Steroid Therapy—Esophageal Varices, Chronic Gastritis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept. , 19 1958 to April , 19 1969 , that (I) (we) last saw the deceased alive on 4/2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>G.O. Himmelwright</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/7/69			
22a. PHYSICIAN'S NAME (Type) G.O. HIMMELWRIGHT, M.D.				22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Apr. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04742										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04736																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last CLAIR Ernest COOPER										Month Day Year APRIL 20, 1969										9:00 P.M.																																							
3. SEX MALE										4. RACE White										5. DATE OF BIRTH 5-15-04										6. AGE (In years last birthday) 64 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										IF UNDER 24 HRS.									
7a. BIRTHPLACE (State or foreign country) W. VA.										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.																			
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give name of place) MEMORIAL HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MANAGER										12b. KIND OF BUSINESS OR INDUSTRY LEWIS THEATRE																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.										13b. COUNTY Greenbrier										13c. CITY OR TOWN LEWISBURG										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 106 NORTH COURT ST																			
14. FATHER'S NAME First Middle Last GORDON LEE COOPER										15. MOTHER'S MAIDEN NAME First Middle Last NANCY E. MEADOWS										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No										16b. SOCIAL SECURITY NO. 033-12-3950										17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 189.0 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypernephroma left kidney with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>extension to adjacent intestines and</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Metastases to lymph nodes - lung (left) & brain</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-20-1969</u> to <u>4-20-1969</u> , that (I) (we) last saw the deceased alive on <u>4-20-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>W.F. Williams</u>										22c. DATE SIGNED <u>4-21-69</u>																																							
22d. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS										22e. ADDRESS CUMBERLAND, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE April 23, 1969										23c. NAME OF CEMETERY OR CREMATORY Hilltop Cemetery										23d. LOCATION (City or Town) (County) (State) Hinton Summers W. Va.																													
24. FUNERAL DIRECTOR H. Wayne George, Cumberland, Md.										25a. REC'D BY REGISTRAR DAP APR 23 1969										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																																							

04740

COPIES OF THIS REPORT WILL BE FURNISHED TO THE FOLLOWING OFFICES:

CLARK, ESTABLISHED, COOPER, APRIL 20, 1953, 1:00 PM

NAME, ADDRESS, CITY, STATE, ZIP

U.S.A., ALABAMA, 36101

MEMORIAL HOSPITAL, CUMBERLAND, MD.

100 NORTH COURT ST, CUMBERLAND, MD.

COOPER, E., HENSON, E.

043-11-3920 MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MD.

APR 23 1953, HENSON, E., COOPER, E.

W. HENSON, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

04743		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04737					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First MARGARET		Middle L.	Last COWAN		2a. DATE OF DEATH Month 4 Day 18 Year 69		9:07 A.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1-6-1924		6. AGE (In years last birthday) 45 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Ballistics Lab					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 106 WILLS CREEK AVE.,			
14. FATHER'S NAME First WILLIAM Middle M. Last HULL		15. MOTHER'S MAIDEN NAME First ANNA Middle C. Last SHUMAN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF last. (c) <u>2 years</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION <u>Sept 68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colon abscission</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>2 March 1967</u> to <u>18 Apr 1969</u> , that (I) (we) last saw the deceased alive on <u>18 Apr 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. F. W. Miltenberger</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>20 Apr 69</u>	
22d. PHYSICIAN'S NAME (Type) DR. F. W. MILTENBERGER		22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

01742

CERTIFICATE OF DEATH

NAME	WILLIAM M. HILL	DATE	1-8-1934
SEX	MALE	AGE	68
RACE	WHITE	PLACE OF BIRTH	ALLEGANY
U.S.A.			

DECEASED	WILLIAM M. HILL	DATE	1-8-1934
SEX	MALE	AGE	68
RACE	WHITE	PLACE OF BIRTH	ALLEGANY
U.S.A.			
DECEASED	WILLIAM M. HILL	DATE	1-8-1934
SEX	MALE	AGE	68
RACE	WHITE	PLACE OF BIRTH	ALLEGANY
U.S.A.			

UP. E. W. HILTBURGER
 124 S. CENTRE ST., CUMBERLAND, MD.
 APR. 21, 1934
 CUMBERLAND, ALLEGANY, MD.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04744										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04738																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First WALTER										Middle A.										Last CROWE										Month 21 Day 1969 Year										9:15 A.M.																			
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH JUNE 6, 1889										6. AGE (In years last birthday) 79 YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.																			
10. CITY OR TOWN OF DEATH FROSTBURG										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BRICK WHEELER										12b. KIND OF BUSINESS OR INDUSTRY BRICK COMPANY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN MT. SAVAGE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
14. FATHER'S NAME First JOSEPH										Middle A.										Last CROWE										15. MOTHER'S MAIDEN NAME First VIRGINIA										Middle KIRBY										Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										(If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 214-01-0129										17. INFORMANT ALOUIS CROWE, FROSTBURG, MD.										Address 21532																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - chronic</u> 582X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerulonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 32 - 8 yrs 2 -																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Severe Anemia</u>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 3-7, 1969, to 4-21, 1969, that (I) (we) lost saw the deceased alive on 4-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Martin Rothstein										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4-22-69																																							
22d. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, MD. D.										22e. ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 4-23-69										23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY										23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.																													
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532										ADDRESS										25a. REC'D BY REGISTRAR APR 24 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

04743

REPUBLIC OF CHINA

MINISTRY OF THE INTERIOR

DEPARTMENT OF POLICE

INVESTIGATION DIVISION

CHINA

BEIJING

APR 21 1954

TO THE DIRECTOR

FROM THE CHIEF

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 5 1969										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04745										04739																			
1. DECEASED-NAME (Type or print)										First Middle Lost										2a. DATE OF DEATH										2b. HOUR																			
JAMES										L. DAVIS										Month 4 Day 28 Year 69										8:45A																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										7. YRS.									
MALE										WHITE										12-20-03										65																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.									
MARYLAND										U.S.A.																				ALLEGANY																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
CUMBERLAND										MEMORIAL HOSPITAL										RETIRED MAINTENANCE										R.R.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND-NUMBER									
MARYLAND										ALLEGANY										FROSTBURG										YES										167 E. MAIN ST.									
14. FATHER'S NAME										First Middle Lost										15. MOTHER'S MAIDEN NAME										First Middle Lost																			
JOHN										R. DAVIS										MARY										A. HOUSE																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																			
																				MEMORIAL HOSPITAL										CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a)										4109										Acute myocardial infarction										7 hr																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										Severe arteriosclerotic heart disease.																													
(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 4/22/69, to 8/28/69, that (I) (we) last saw the deceased alive on 4/27/69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE										W. A. Himmler										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 5-3-69																			
22d. PHYSICIAN'S NAME (Type)										DR. W. A. HIMMLER										22e. ADDRESS										CUMBERLAND, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
BURIAL										5-1-69										FEB. MEMORIAL PARK										FROSTBURG, MD.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
JOSEPH R. DURST, SR.,										FROSTBURG, MD. 21532										MAY 5 1969										Charles Judge																			

• 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04746		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04740					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
LESLIE			HOLMES	DEMPSAY	APRIL 11		Month	Day	1969	11:25	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		11-1-12		56		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
NEBRASKA		USA				ALLEGANY				MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSP.			Electrician			Celanese		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY			CUMBERLAND				ROUTE #5 Bowling Green	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
ALEXANDER			W.	DEMPSAY		SEAR			SARAH	MARGARET	SEARS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No.			481-09-0408			MEMORIAL HOSP., CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>										6 wks	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of R. Lung</u>										6 mon	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Secondary carcinoma</u>										6 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> , 19 <u>69</u> , to <u>Apr 11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Apr 11</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clay E. Durrett</u>						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/12/69</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
DR. CLAY DURRETT						CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4/17/69		Graceland Park Cemetery			Sioux City, Woodbury, Iowa			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Wayne George 202 Greene St. Cumberland, Md.								APR 15 1969		<u>Charles Judge</u>	

125 : 1 : 1 : 1

32-11-11

NOTE

1952/53

10-09-68 MEMPHIS TEL 44-1029

CUMBERLAND AND . . .

Exercice 1 : Soit f la fonction définie sur \mathbb{R} par :

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04747

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04741

1. DECEASED-NAME (Type or Print) Elwood Weldon Dorsey			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year April 12, 1969			2b. HOUR 8:05 p				
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH 12/15/99	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month April 12, Day 1969 Year 19			2d. HOUR 8:05 p		
7a. BIRTHPLACE (State or foreign country) Cumberland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany			Md.	
10. CITY OR TOWN OF DEATH Cumberland Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Laborer			12b. KIND OF BUSINESS OR INDUSTRY Construction				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 622 Bedford St. Cumb. Md.	
14. FATHER'S NAME John Dorsey			First Middle Last			15. MOTHER'S MAIDEN NAME Anna Taxer			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Memorial Records			ADDRESS Cumberland Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ---													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> 22b. DATE SIGNED April 12, 1969													
ACTUAL SIGNATURE Benedict Skitarelic			EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/16/69			23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.			23d. LOCATION (City or Town) (County) (State) Cumberland Md. (Allegany)				
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md.			ADDRESS			25a. REC'D BY REGISTRAR APR 16 1969			25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				

04747

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10/15/1918	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		New York City		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses	
Clerk		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Medical Examiner	
10/15/1918		10:00 AM		New York City		[Signature]	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04748

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04742

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR	
Dorothy			June			Elliott			April 30, 1969			11:54 P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Female	White	June 17, 1922	46					APRIL 30, 1969			11:54 P		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		USA				Allegany Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			MEMORIAL HOSPITAL--DOA			Housewife			Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.			Allegany			Cumberland				353 Dorn Ave.			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Walter H. Simpson			Bella L. Brown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
no						Mr. Joseph W. Elliott, Cumberland Md. Husband							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												ASPHYXIATION STATUS EPILEPTICUS MINUTES ---	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				XX April 30, 1969					
				ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			May 3, 1969		Frostburg Memorial Park			Frostburg, Allegany, Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.								DATE MAY 6 1969		<i>Charles Judge</i>			

14742

Thorpe June 1910

Female White June 15, 1922 46

Partially USA

Cambridge

Mr. Albany Cambridge x 555 Town Ave.

Walter H. Robinson

Bella L. Brown

Hubbard

Mr. Joseph A. Elliot, Cambridge.

Albany

STATE STREET

Barrel May 5, 1920 Front Street, Albany, N.Y.

James P. Corbett, Cambridge, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>04743</div> <div>CERTIFICATE OF DEATH</div> <div>04743</div>									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
First Middle Last WOODROW S ELLIOTT					Month Day Year APRIL 27, 1969		PM 11:22		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		8-31-1918		50 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNA		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			MEMORIAL HOSPITAL			Boilermaker- B & O R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MD.			ALLEGANY CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 BEDFORD ST.,		
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
SHANNON ELLIOTT					MAUDE M. ZEMBOWER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			WW II		174-16-8676 MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus with Metastases 150X DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19____, to April 27 , 19 69 , that (I) (we) last saw the deceased alive on April 25 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Calvin Y. Hadidian					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/30/69		
22d. PHYSICIAN'S NAME (Type) DR. CALVIN HADIDIAN					22e. ADDRESS 203 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/30/69		Sunset Memorial Park		Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR ADDRESS 21502					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Silcox- Merritt Funeral Service, Cumberland, MD					MAY 2 1969		Charles Judge		

04743

STATE OF NEW YORK

IN SENATE, JANUARY 11, 1906.

APRIL 27, 1906, 11:11

ELLIOTT

2

ROOMS

30

1-21-1910

WHITE

MALE

ALLEGANY

USA

PENNA

MEMORIAL HOSPITAL

CUMBERLAND

1100 GREENE ST.,

CUMBERLAND, N

ALLEGANY

MD.

RENUMBER

MADE

ELLIOTT

SHAWNY

MEMORIAL HOSPITAL, CUMBERLAND, MD.

1-21-1910

WHITE

MALE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04750

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04744

1. DECEASED-NAME (Type or Print) First Middle Last Florence Emerick			2a. DATE OF DEATH Month Day Year April 18, 1969			2b. HOUR OF DEATH About 6a M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH 6.21.1919	6. AGE (In years last birthday) 49 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year April 18, 1969 Year 19			2d. HOUR 3 p M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Cumberland, Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 214 Decatur Street			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 214 Decatur St.
14. FATHER'S NAME First Middle Last Henry E. Lowery			15. MOTHER'S MAIDEN NAME First Middle Last Emma Devore Lowery						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-46-2301		17. INFORMANT Mrs. Paulette McCoy, Hyndman, Pa		ADDRESS 15545		RD#1
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis 4109									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours 11 -----
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 18, 1969	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or County) Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		23d. LOCATION (City or Town, State, County) Cumberland, Md.			
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa.				ADDRESS 15545		25a. REC'D BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE James J. Zeigler	

02540

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 12 5/15/69 kk 04751												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04745																																			
1. DECEASED-NAME (Type or Print) HEZEKIAH First Middle Last												2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month April Day 16 Year 1969 2b. HOUR 7:15 P M																																			
3. SEX MALE				4. RACE COLORED				5. DATE OF BIRTH Jan. 22, 1902				6. AGE (In years last birthday) 67 YRS				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.				2c. DATE PRONOUNCED DEAD Month April Day 16 Year 1969 2d. HOUR 7:15 P M																							
7a. BIRTHPLACE (State or foreign country) CUMBERLAND						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH ALLEGANY Md.																													
10. CITY OR TOWN OF DEATH CUMBERLAND MD.						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 104 N. MECHANIC STREET.						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER						12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND						13b. COUNTY ALLEGANY						13c. CITY OR TOWN CUMBERLAND						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER 104 N. MECHANIC ST.																							
14. FATHER'S NAME First PETER Middle Last												15. MOTHER'S MAIDEN NAME First MARY Middle Last MEEKINS																																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes give war or dates of service)												16b. SOCIAL SECURITY NO.												17. INFORMANT BERNARD FAGAN MARTINSBURG W.VA. ADDRESS																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN --																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)												21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												22b. DATE SIGNED APRIL 16 1969																							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.												ADDRESS (Street, city, town, or county) Cumberland, Maryland																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL												23b. DATE 4/19/69												23c. NAME OF CEMETERY OR CREMATORY ALLEGANY COUNTY CEMETERY												23d. LOCATION (City or Town) (County) (State) CUMBERLAND ALLEGANY MD.											
24. FUNERAL DIRECTOR <i>Louis Stein Inc.</i>												ADDRESS <i>Cumberland Md.</i>												25a. REC'D BY REGISTRAR APR 22 1969												25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>											

2

U.S. GOVERNMENT PRINTING OFFICE: 1965

DEPARTMENT OF THE ARMY

19/11/59

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04752

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04746

1. DECEASED-NAME (Type or Print) JOSEPH			First A.			Middle FINN			Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year April 24, 1969			2b. HOUR 8 a.m.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 19, 1905		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 24, 1969			2d. HOUR 8 a.m.				
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY							
10. CITY OR TOWN OF DEATH FROSTBURG				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 183 W. MECHANIC ST.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PATROLMAN				12b. KIND OF BUSINESS OR INDUSTRY STATE COLLEGE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN FROSTBURG				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 183 W. MECHANIC ST.					
14. FATHER'S NAME First Middle Last ANDREW FINN						15. MOTHER'S MAIDEN NAME First Middle Last MARY HIGGINS													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-07-5311				17. INFORMANT ADDRESS MRS. ANGELA FINN, FROSTBURG, MD. 21532											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ---														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED April 24, 1969 ADDRESS (Street, city, town, or county) Gumberland, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE APR. 26, 1969				23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.							
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532										25a. REC'D BY REGISTRAR DATE APR 29 1969				25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>					

0438

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) IRENE First Middle Lost					2a. DATE OF DEATH Month 4 Day 22 Year 69				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-14-1904			6. AGE (In years lost birthday) 64 YRS.		2b. HOUR 9:55 A.M.
7a. BIRTHPLACE (State or foreign country) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 824 YALE ST.,
14. FATHER'S NAME EDWARD LOUIS Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost SAGADY ELIZABETH LUNSLO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-26-9320		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-cellular Carcinoma 5718 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to Portal Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) With Marked Liver Dysfunction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-7-69 , 19 69 , to 4-22-69 , 19 69 , that (I) (we) last saw the deceased alive on 4-21-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm. F. Williams					22c. DATE SIGNED 4-24-69				
22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS					22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/1969		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.			
24. FUNERAL DIRECTOR Charles E. Hafer					25a. REC'D BY REGISTRAR APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles E. Hafer		

04333

STATE OF NEW JERSEY

1928

STATE

STATE

11-1-1901

WHITE

WHITE

ALLIANCE

NEW JERSEY U. S. A.

CHICAGO

CHICAGO

ALLIANCE CHICAGO X 121 YALE ST.

WHITE

WHITE

WHITE

CHICAGO - 121 YALE ST. CHICAGO - 121 YALE ST.

CHICAGO - 121 YALE ST.

CHICAGO - 121 YALE ST.

APR 28 1928

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1

04754		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04748	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
GEORGE		V.		FOSTER	APRIL 21 1969		3:30 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IE UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		MAY 14, 1900		68 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.	
INDIANA		USA		ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		Conductor		RAILROAD	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND		Alleg.		RAWLINGS		RAWLINGS HEIGHTS	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
FRANK				FOSTER	URSULA		ARBUCKLE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
YES		705-10-1592		HOSPITAL RECORD- 900 SETON DRIVE, CUMB., MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branching Cerebral Hemorrhage</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>68</u> , to <u>April 21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B.M. Schindler</u>				DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED 4/21/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
B.M. SCHINDLER, M.D.				43 GREENE ST., CUMBERLAND, MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/23/69		Sunset Memorial Park		Cumberland Allegany Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB. MD.				APR 23 1969		G. Charles Judge	

ADP: 2051

YWA0211A

WILLARD

2TH01EH 2041JVA

APR 1964

HOSPITAL RECORD - 000 SECTION DRIVE, CUMMINS, IN.

43 GREENE ST., CHICAGO, ILL. 51205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04755		CERTIFICATE OF DEATH				04749			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Irene E. Frye						4 Month 23 Day 69 Year			1:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		January 3, 1896		73 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. Virginia		Allegany				Allegany, Cumberland Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Alle. C. Infirmary			Housewife			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER
Ma.			Allegany			YES			223 Arch Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Peter Henry Mouse			Mary Ellen Kerns						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			705-10-8574			Homer W. Frye, 223 Arch Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Old ASHD - Mitral Dam. previous</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus. P.V.D. (3) High blood pressure. Obesity, 300.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Four minutes</u> <u>many years</u> <u>many years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22d. I certify that (I) (this hospital) attended the deceased from April 7, 1969, to April 23, 1969, that (I) (we) last saw the deceased alive on April 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
John A. Topper M.D.			4-24-69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
John A. Topper M.D.			Memorial Hospital Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 26, 1969		Sunset Memorial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.			DATE APR 28 1969			[Signature]			

3520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
KELLEY		MARIE		FRYE				Month <input checked="" type="checkbox"/> Day Year		5p M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Female	White	Jan. 2, 1966		3 YRS.					Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S.				Allegany Md.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Cumberland				Memorial Hospital--DOA				None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
W, Va.				Hampshire		Greenspring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
First Middle Last				First Middle Last						
Robert L. Frye				Vickie L. Twigg						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No				None		Robert L. Frye, Greenspring, W, Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										Minutes
IMMEDIATE CAUSE (a) Asphyxiation										
DUE TO, OR AS A CONSEQUENCE OF Drowning										"
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
about 4 P.M. April 5, 1969				Fell in recently excavated water hole						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home (yard)		Greenspring, Mineral county, West Virginia						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 5, 1969		
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		April 8, 1969		Forest Glen		Greenspring Hampshire		W, Va.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Romney, W, Va.						APR 8 1969		Charles Judge		

04756

MEDICAL EXAMINATION CERTIFICATE OF DEATH

Name		Age		Sex		Race		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Coroner		Signature of Medical Examiner	
John Doe		45		Male		White		1930		1975		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Address		Occupation		Education		Marital Status		Previous Illnesses		Previous Injuries		Previous Operations		Previous Hospitalizations		Previous Deaths		Previous Dispositions		Previous Treatments		Previous Medications		Previous Diets	
123 Main St		Teacher		High School		Married		Hypertension		None		None		None		None		None		None		None		None	
History of Present Illness		History of Past Illnesses		History of Past Injuries		History of Past Operations		History of Past Hospitalizations		History of Past Deaths		History of Past Dispositions		History of Past Treatments		History of Past Medications		History of Past Diets		History of Past Habits		History of Past Interests		History of Past Hobbies	
Patient was found dead in bed		Patient had no known illness		Patient had no known injuries		Patient had no known operations		Patient had no known hospitalizations		Patient had no known deaths		Patient had no known dispositions		Patient had no known treatments		Patient had no known medications		Patient had no known diets		Patient had no known habits		Patient had no known interests		Patient had no known hobbies	
Physical Examination		Vital Signs		Cardiovascular		Respiratory		Gastrointestinal		Genitourinary		Neurological		Musculoskeletal		Dermatological		Ophthalmological		Otolaryngological		Endocrinological		Immunological	
Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal	
Laboratory Tests		X-ray		ECG		Chest X-ray		Abdominal X-ray		Skull X-ray		Spine X-ray		Joint X-ray		Skin Biopsy		Eye Exam		Ear Exam		Thyroid Exam		Allergy Test	
None		None		None		None		None		None		None		None		None		None		None		None		None	
Pathological Findings		Microscopic Findings		Immunohistochemistry		Cytology		Flow Cytometry		Genetics		Proteomics		Metabolomics		Toxicology		Immunology		Microbiology		Molecular Biology		Biochemistry	
No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings		No significant findings	
Conclusion		Recommendations		Follow-up		Referral		Consultation		Second Opinion		Third Opinion		Fourth Opinion		Fifth Opinion		Sixth Opinion		Seventh Opinion		Eighth Opinion		Ninth Opinion	
Patient died of natural causes		Patient should be monitored		Patient should be treated		Patient should be referred		Patient should be consulted		Patient should be second opinion		Patient should be third opinion		Patient should be fourth opinion		Patient should be fifth opinion		Patient should be sixth opinion		Patient should be seventh opinion		Patient should be eighth opinion		Patient should be ninth opinion	
Date of Report		Time of Report		Place of Report		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Radiologist		Signature of Toxicologist		Signature of Immunologist		Signature of Microbiologist		Signature of Molecular Biologist		Signature of Biochemist	
1975		10:00 AM		Home		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04757

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04751

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First ELMER	Middle LEROY	Last GARLITZ	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year April 13, 1969			2b. HOUR 2:20 p.m.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH DEC. 14, 1906	6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 13, 1969	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CONSTRUCTION			12b. KIND OF BUSINESS OR INDUSTRY BURTON CONSTRUCTION CO.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY GARRETT		13c. CITY OR TOWN FROSTBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 2	
14. FATHER'S NAME First Middle Last NORMAN C. GARLITZ			15. MOTHER'S MAIDEN NAME First Middle Last RHODA ROBINSON			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16b. SOCIAL SECURITY NO. 220-16-6705			17. INFORMANT ADDRESS MRS. RHODA GARLITZ, RT. 2, FROSTBURG, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transection of Cervical Spinal Cord DUE TO, OR AS A CONSEQUENCE OF Fracture of Atlas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 Hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 2:00 P.M. April 12, 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down steps				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State R#2 Frostburg, Allegany, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarellic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> XXX ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			22b. DATE SIGNED April 13, 1969						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 16, 1969		23c. NAME OF CEMETERY OR CREMATORY BLOCHER CEMETERY			23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST, FROSTBURG, MD. 21532					25a. REC'D BY REGISTRAR DATE APR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

04757

RECEIVED BY THE DIRECTOR, BUREAU OF INVESTIGATION, U.S. DEPARTMENT OF JUSTICE, APRIL 17 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First ALICE		Middle S.		Last GILBERT		2a. DATE OF DEATH APRIL Month 17 Day 1969		2b. HOUR 12:20A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4-24-88		6. AGE (In years on birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 355 National Hwy			
14. FATHER'S NAME First JOHN		Middle ENGLE		Last AMANDA		15. MOTHER'S MAIDEN NAME First AMANDA		Middle SWARNER		Last SWARNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSP., CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction c Vent. F.</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 15 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.O. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>69</u> , to <u>4-17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles P. Dross</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-22-69	
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS		22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.					
24. FUNERAL DIRECTOR William G. Kight		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <u>William G. Kight</u>					

04752

STATE OF OHIO

DEPARTMENT OF HEALTH

ALICE GILBERT

ALICE GILBERT

WHITE

USA

MEMORIAL HOSPITAL

ALICE Y. LA VAIL

BRAND

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CR. V. PRESS

BRITISH G. RIGHT

CUMBERLAND, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04759

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04753

1. DECEASED-NAME (Type or print)			First Alice	Middle May	Last Godwin	2a. DATE OF DEATH Month April Day 27, 1969 Year 1969			2b. HOUR P 4:00 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 15, 1887			6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife,			12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.			13b. COUNTY Bedford		13c. CITY OR TOWN Bedford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 127 So. Wood St.			
14. FATHER'S NAME First John Middle Leslie Last Jones			15. MOTHER'S MAIDEN NAME First Laura Middle Adeline Last Moss									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No,			16b. SOCIAL SECURITY NO. None			17. INFORMANT Address Bedford, Penna. Mrs. E. Jeanne Fetters 127 So. Wood St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmo vascular disease</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>3-15-</u> , 19 <u>68</u> , to <u>4-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>L Brings</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>4-22-69</u>		
22d. PHYSICIAN'S NAME (Type) Dr. Lewis Brings				22e. ADDRESS 57 Greene St. Cumberland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/69		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery,			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						25a. RECEIVED BY REGISTRAR APR 25 1969 DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04760										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04754									
Item 13 Film 412 5/19/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First JOHN					Middle EWING					Last GROWDEN					2a. DATE OF DEATH APRIL Month 19 Day 1969					2b. HOUR 2:45A				
3. SEX MALE					4. RACE WHITE					5. DATE OF BIRTH 12-20-84					6. AGE (In years last birthday) 84 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) PA.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH ALLEGANY Md.														
10. CITY OR TOWN OF DEATH CUMBERLAND					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. Pa.					13b. COUNTY Bedford					13c. CITY OR TOWN CUMBERLAND					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER RT. # 3									
14. FATHER'S NAME First ELLSWORTH					Middle GROWDEN					Last MARY					15. MOTHER'S MAIDEN NAME First E.					Middle HARDINGER					Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO					16b. SOCIAL SECURITY NO. 219-46-0185					17. INFORMANT Address MEMORIAL HOSP., CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from June, 1965, to 4-19, 1969, that (I) (we) lost saw the deceased alive on 4-18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE William P. James, MD															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 4-19-69									
22d. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M. D.															22e. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE APRIL 19, 1969					23c. NAME OF CEMETERY OR CREMATORY CENTENARY CEMETERY					23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.														
24. FUNERAL DIRECTOR BYRON KIGHT															ADDRESS CUMBERLAND, MD.					25a. REC'D BY REGISTRAR DATE APR 23 1969					25b. REGISTRAR'S SIGNATURE William P. James				

04760

CRIMINAL RECORD

JOHN E. BROWN

WHITE

ALLIANCE

CLINTON COUNTY HOSPITAL

CLINTON COUNTY

CLINTON COUNTY

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

CLINTON COUNTY HOSPITAL, CLINTON, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
04761																	
CERTIFICATE OF DEATH																	
04755																	
1. DECEASED-NAME (Type or print)			First JOHN			Middle W.			Last HALL SR.			2a. DATE OF DEATH Month APRIL 27 Day 1969 Year			2b. HOUR 6:00P M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JUNE 16, 1910			6. AGE (In years last birthday) 58 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) QUALITY CONTROL TECH.			12b. KIND OF BUSINESS OR INDUSTRY CELANESE								
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CRESAPTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME WALTER			First Middle Last HALL			15. MOTHER'S MAIDEN NAME MARY GORDON			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) NO			16b. SOCIAL SECURITY NO. 214-07-4210			17. INFORMANT Address HOSPITAL RECORDS-900 SETON DRIVE, CUMB., MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic cardiac failure</u> 425X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial degeneration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension over years ago</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 12 yrs. 4					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>cardiac hepatic overwork, renal failure</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>5/7</u> , 19 <u>67</u> , to <u>4/27</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4/27/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Elizabeth Brings, M.D.</u>			22c. DATE SIGNED 4/27/69			22d. PHYSICIAN'S NAME (Type) ELIZABETH BRINGS, M.D.											
22e. ADDRESS 55 GREENE ST., CUMBERLAND, MD. 21502																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/30/1969			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.								
24. FUNERAL DIRECTOR <u>John J. Hafer</u>			24a. ADDRESS HAFER FUNERAL HOME - LA VALL, MD. 21502			25a. REC'D BY REGISTRAR MAY 1 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

JOHN W. HALL
 WHITE
 JUNE 10, 1910
 ALLEGANY
 PENNSYLVANIA
 CURTIS
 SACRED HEART HOSPITAL
 QUALITY CONTROL TECH. CENTER
 ALLEGANY
 ALLEGANY
 HALL
 HALL
 214-07-4210
 HOSPITAL RECORDS-000 SETON DRIVE, CUMBS, N.Y.

ELIZABETH BRINGS, N.Y.
 25 GREENE ST., CURTIS, N.Y. 21202
 HALLER FORTAL HOME - LA VILLE, N.Y. 21202

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04756	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
Thomas			J.		Jones				4/11/1969		M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR
Male	White	2/25/1886		83 YRS.					4th Day 11th, Year 1969		M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Nikep								Retired		Miner	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.				Allegany		Nikep					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME	
EBENEIZER				JONES						Carolyn Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
Spanish-American				220-10-1053		Melvin J. Jones, (Son)				Nikep, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				4/11/1969			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
								Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/13/1969		Laurel Hill Cemetery		Moscow, Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GEORGE EICHHORN, Lonaconing, Md.								APR 16 1969		<u>Charles Judge</u>	

NOTES
DATE

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RESEARCH DIVISION - BUREAU OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04763		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04757	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. PM
ERNEST		L		KELLER	APRIL 28 1969		9:30
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		2-13-1911		58 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.	USA			ALLEGANY Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL		SUPERVISOR		COLUMBIA GAS		
13a. USUAL RESIDENCE (Where deceased admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
MD.	ALLEGANY CUMBERLAND			RT. 3, BEDFORD RD.,			
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle
ERNEST			KELLER	MARIE TTA			TROUT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO		214-05-9172		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thromboses</u> DUE TO, OR AS A CONSEQUENCE OF <u>Art. Self Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>5 yr</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
				Cypress Alley Md			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27/69</u> , 19 <u>69</u> , to <u>4/28/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/27/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE, SIGNED	
<u>Dr. R. J. Williams</u>						<u>5/1/69</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE, SIGNED			
DR. R. J. WILLIAMS		122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	5/1/1969	Hillcrest Burial Park		Near Cumberland Alleg Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>John J. Hafer, Jr.</u>		230 Balto Ave. Cumberland, MD		MAY 5 1969		<u>Charles Judge</u>	

04768

DEPARTMENT OF DEATH

APRIL 28 1968 3:30 PM

WELLS

ERNEST

L

WHITE

WHITE

2-13-1911

X

USA

USA

ALLEGANY

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

ALLEGANY COUNTY

MD.

WELLS

ERNEST

2-13-1911

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. R. A. WILLIAMS

152 S. CENTRE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04764				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04758			
Item 5 Film 411 4/14/69 kk				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First MIDDLE Last ELLA S KORNS				2a. DATE OF DEATH Month Day Year 4 3 69				2b. HOUR 11:00 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-8-90 1891				6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY HYNDMAN		13c. CITY OR TOWN HYNDMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1			
14. FATHER'S NAME First MIDDLE Last SAMUEL LEPLEY				15. MOTHER'S MAIDEN NAME First MIDDLE Last IDA EMERICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 172-18-0971		17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral emboli & RT. peripheral emboli</u> <u>4121</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis & hypercholesterolemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>9 yr</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Stroke</u> <u>Hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July, 19 68</u> , to <u>3 April 19 69</u> , that (I) (we) last saw the deceased alive on <u>3 April 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S. G. Weisman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3 April 1969</u>					
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22e. ADDRESS CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Cooks Cemetery				23d. LOCATION (City or Town) (County) (State) Wellersburg, Somerset Co. Pa.			
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa. 15545				25a. REC'D BY REGISTRAR APR 9 1969				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

04254

DEPARTMENT OF HEALTH

09 11:00A

ROBINS

2

BLA

RE ALB WHITE 5-8-20
PENNSYLVANIA U.S.A.
ALLEANY

COMBERLAND HOSPITAL

PENNA. HINDMAN RT. 1

SAMUEL LEBLEY IDA EMERICK

COMBERLAND HOSPITAL

DR. S. G. WEISMAN COMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
CLARA Belle B.				LAEMMERT	APRIL Month 4 Day 1969 Year	1A M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
FEMALE	WHITE		MAY 2, 1886		82 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND	U.S.A.				ALLEGANY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG		40 WASHINGTON ST.		HOUSE WIFE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND		ALLEGANY		FROSTBURG		40 WASHINGTON STREET
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Luke		WILLIAM	Van	ROBERTSON	TILDA MIDDLETON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
		215-10-4466A		RALPH A. LAEMMERT, FROSTBURG, MD. 21532		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Cordiac Failure</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF <u>AH CVD-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3+ years.</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>11</u> , 19 <u>66</u> , to <u>4/4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		
John B. Davis,		4/4/69-		JOHN B. DAVIS, M. D.		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS		
		2 JOHN B. DAVIS, M. D.		2 BROADWAY, FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		4-7-69	FBG. MEMORIAL PARK		FROSTBURG, MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
JOSEPH. R. DURST, FROSTBURG, MD. 21532				DATE APR 7 1969		Charles Judge

00305



Handwritten notes and printed text, mostly illegible due to blurriness and redaction. Visible fragments include:

- Top left: "11"
- Top center: "CAPTION OF DEATH"
- Top right: "CLARK, JAMES A."
- Middle left: "JAMES A. CLARK"
- Middle center: "JAMES A. CLARK"
- Middle right: "JAMES A. CLARK"
- Bottom left: "JAMES A. CLARK"
- Bottom center: "JAMES A. CLARK"
- Bottom right: "JAMES A. CLARK"

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pending item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 File # 11m G112 4/30/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										04766			
1. DECEASED-NAME (Type or Print) First Middle Last Roy Edward Leasure						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year April 17, 1969				2b. HOUR 6a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 11, 1899		6. AGE (In years last birthday) 70 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year April 17, 1969		2d. HOUR 6a M			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Gardener			12b. KIND OF BUSINESS OR INDUSTRY Flower				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany Cumberland			13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 168 Columbia St.		
14. FATHER'S NAME First Middle Last George Leasure						15. MOTHER'S MAIDEN NAME First Middle Last Rose Valentine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Brother Mr. Russell Leasure, Cumberland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden " ---			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarellic</i> M.D. EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cumberland, Maryland							
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial						23b. DATE Apr. 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

April 17, 1969

April 17, 1969

April 17, 1969

April 17, 1969

April 17, 1969

April 17, 1969

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April 17, 1969

April 17, 1969

April 17, 1969

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1000. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04767

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04919
April 30, 1969

1. DECEASED-NAME (Type or Print)		First Robert		Middle Hall		Last Loffert		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> XXXXXX 1969		2b. HOUR 3:30 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 11, 1924		6. AGE (In years last birthday) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD May 1, 1969 Year 19 3:00a M	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH La Vale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 420 National Highway				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Industrial Engineer-Glass Ind.				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 420 National Highway			
14. FATHER'S NAME First John Middle Loffert Last				15. MOTHER'S MAIDEN NAME First Ella Middle Kelly Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. War II		17. INFORMANT ADDRESS Mrs. Edith Loffert, La Vale, Md.-Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, Left DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis, Left (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden " ----	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED May 1, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) New Kensington, (W.M.) Pa.					
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

04707

MEDICAL EXAMINER - OFFICE OF DEATH

April 30, 1969

10:00 AM - 11:00 AM

10:00 AM

11:00 AM

12:00 PM

3:00 PM

May 1, 1969

Nov. 11, 1968

Male - White

Allegany

USA

Female

Industrial - Highway - Glass Ind.

420 National Highway

in Vale

420 National Highway

Allegany in Vale

Male

Bill Kelly

10:00 AM

John

Mrs. Edith Telford, in Vale, Md. - White

Yes - White

Shaded

Coronary occlusion, left

"

Coronary Thrombosis, left

Coronary Arteriosclerosis

X

X

X

X

X

May 1, 1969

Chancellor, Maryland

Penobscot, Maine, W.D.

New Kensington, W.D.

May 3, 1969 - Union Cemetery

James E. Bortwell, Cumberland, Md.

James E. Bortwell, Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

04768										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
Item 2 Film 411 4/9/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Dolly					Mae					Lynch					Month Day Year April 12, 1969					9:30A									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					7. IF UNDER 1 YEAR MONTHS DAYS					8. IF UNDER 24 HRS. HOURS MIN.				
Female					White					August 25, 1902					66 YRS.														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
West Virginia					U S A										Allegany					Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Cumberland					712 White Avenue					Coning (Retired)					Celanese														
13a. USUAL RESIDENCE (Where deceased adjoined) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Allegany					Cumberland										712 White Avenue									
14. FATHER'S NAME					First Middle Last					15. MOTHER'S MAIDEN NAME					First Middle Last														
Frank					Iliff					Rose					Kenney														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
No					214-07-3706					Mrs. James King, Jr.					712 White Ave.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b) <u>Arteriosclerotic Heart Disease</u>										2 yrs.																			
DUE TO, OR AS A CONSEQUENCE OF																													
(c) <u>Diabetes Mellitus</u>										2 yrs.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 2/10, 1967, to 4/12, 1969, that (I) (we) last saw the deceased alive on 3/14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE <u>J. A. Pagan</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 4/2/69																			
22d. PHYSICIAN'S NAME (Type)					J. A. Pagan, M.D.					22e. ADDRESS 1068 National Hwy., LaVale, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					4/4/1969					Sts. Peter & Paul Cem.					Cumberland Alleg Md														
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Charles E. Hoffer					240 Balto Ave. Cumberland Md					APR 7 1969					Charles Judge														

2850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 PM
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Lost			20. DATE OF DEATH			2b. HOUR
EMMA			CECELIA LYNCH			APRIL 16, 1969			9:15 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		JULY 5, 1893		75 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
FROSTBURG, MD.		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FROSTBURG		MINERS HOSPITAL		HOUSEWIFE		OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		FROSTBURG				147 ORMOND STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
First Middle Lost			First Middle Lost			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			
JOSEPH			MAUREY			NO N.A.			
16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
			MR. JOSEPH LYNCH, 263 CENTENNIAL ST.			FROSTBURG, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								Sudden	
IMMEDIATE CAUSE (a) Coronary occlusion									
DUE TO, OR AS A CONSEQUENCE OF Hypertension									
DUE TO, OR AS A CONSEQUENCE OF Arterio-sclerosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Obesity									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-11, 1969, to 4-16, 1969, that (I) (we) last saw the deceased alive on 4-16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
H. C. Diehl, M.D.		4/19/69		H. C. DIEHL, M.D.					
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS					
39 W. MAIN, FROSTBURG, MD.		39 W. MAIN, FROSTBURG, MD.		39 W. MAIN, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. LOCATION (City or Town) (County) (State)	
BURIAL		4/19/69		ST. MICHAEL'S CEMETERY		FROSTBURG, ALLEGANY, MD.		FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
MARTIN M. SOWERS		HOME, 60 W. MAIN, FROSTBURG		APR 22 1969					

04779

OFFICE OF THE
SHERIFF OF DEPT.

NAME: LYNCH, JAMES
ADDRESS: 101 10th St.
CITY: ST. LOUIS, MO.

DATE: JULY 2, 1935
TIME: 10:00 AM

RE: JAMES LYNCH, JR.
U.S. DEPT. OF JUSTICE

REPORTED BY: JAMES LYNCH, JR.
REPORTED AT: ST. LOUIS, MO.

REPORTED ON: JULY 2, 1935
REPORTED BY: JAMES LYNCH, JR.

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REPORTED BY: JAMES LYNCH, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04770		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04763	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last SCOTT M. MANN			2a. DATE OF DEATH Month Day Year APRIL 4 1969			2b. HOUR 1:45A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8-31-81		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LITTLE ORLEANS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last DENTON MANN		15. MOTHER'S MAIDEN NAME First Middle Last SARAH SCOTT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-14-7835		17. INFORMANT Address 35 MEMORIAL HOSP., CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis progressive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>bilateral pneumonias</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> , 19 <u>69</u> , to <u>4-3</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4-3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. V. Dross</u>		22c. DATE SIGNED 4-4-69		22d. PHYSICIAN'S NAME (Type) DR. V. DROSS		22e. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4.6.69		23c. NAME OF CEMETERY OR CREMATORY PINEY PLAINS		23d. LOCATION (City or Town) (County) (State) RURAL ALLEGANY MD.	
24. FUNERAL DIRECTOR GROVE FUNERAL HOME		ADDRESS HANCOCK, MARYLAND		25a. REC'D BY REGISTRAR 10 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04770

UNITED STATES OF AMERICA

SCOTT 1 APRIL 1969

MALE WHITE 8-21-81 ALLEGANY

CLAMBERLAND MEMORIAL HOSP.

ALLEGANY LITTLE ORRIS X

SCOTT 2000

214-14-2000 MEMORIAL HOSP., CUMBERLAND, MD.

1-1-81

US. V. CROSS CUMBERLAND, MD.

RURAL ALLEGANY MD. PINEY PLAINS

GROVE TUBERIAL HOME HANCOCK, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
047771																	
04764																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First MARY			Middle G.			Lost MATHIAS			2a. DATE OF DEATH Month 18 Day 1969 Year			2b. HOUR M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH JAN. 15, 1886			6. AGE (In years last birthday) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) D. C.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 36 FROST AVENUE					
14. FATHER'S NAME First PATRICK			Middle McGUIRE			Lost McGUIRE			15. MOTHER'S MAIDEN NAME First CATHERINE			Middle DRISCIL			Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 214-01-0063-B			17. INFORMANT Address MAXWELL J. MATHIAS, FROSTBURG, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic heart disease 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Bruise + abrasion L. facet Knee Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3-69							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senility																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1-3 , 19 69 , to 4-18 , 19 69 , that (I) (we) last saw the deceased alive on 4-18 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE H. C. Diehl, M.D.			DEGREE H. C. DIEHL, M. D.			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE, SIGNED 4/19/69.					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 39 WEST MAIN ST., FROSTBURG, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-21-69			23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.								
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.			ADDRESS 21532			25a. REC'D BY REGISTRAR DATE APR 23 1969			25b. REGISTRAR'S SIGNATURE W. C. Jones								

04773

STATE OF OHIO
COUNTY OF CUYAHOGA

IN SENATE,
JANUARY 12, 1903.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

AND

OF THE

LANDS BELONGING TO THE STATE OF OHIO

FOR THE YEAR ENDING DECEMBER 31, 1902

ALBION B. HARRIS, COMMISSIONER

ALBION B. HARRIS, COMMISSIONER

ALBION B. HARRIS, COMMISSIONER

ALBION B. HARRIS, COMMISSIONER

ALBION B. HARRIS, COMMISSIONER

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ALBION B. HARRIS, COMMISSIONER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be excluded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04772

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04765

1. DECEASED-NAME (Type or print) ROSE			First C. Middle MC Last CORMICK			2a. DATE OF DEATH Month 10 Day 1969 Year 12:10A			2b. HOUR								
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 6-21-81			6. AGE (In years on birthday) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY WON HOME								
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1105 KENTUCKY AVE.					
14. FATHER'S NAME First ALEX Middle LEASURE Last FRANCES BRINKER			15. MOTHER'S MAIDEN NAME First FRANCES Middle BRINKER Last BRINKER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address MEMORIAL HOSP., CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary sclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks 1 yr 10 yrs																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from June 1968 to Apr. 10, 1969 , that (I) (we) last saw the deceased alive on Apr 9 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Clayton J. Durrett			22c. DATE SIGNED 4/10/69			22d. PHYSICIAN'S NAME (Type) DR. DURRETT											
22e. ADDRESS CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Apr. 12, 1969			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE APR 14 1969			25b. REGISTRAR'S SIGNATURE William J. Gude								

DOI: 10.1002/for

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1105 HERIOT AVENUE,

LEARNER, AL. HOST, COUNSELLOR AND, IN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04773		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04766					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) MARY			First M. Middle McDONALD Last			2a. DATE OF DEATH Month APRIL Day 2 Year 1969		2b. HOUR 2 P.M.			
3. SEX FEMALE		4. RACE W		5. DATE OF BIRTH 7-26-1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) HARRISBURG, VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CUMBERLAND Nursing & Convalescent Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY 				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 340 BALTIMORE AVENUE			
14. FATHER'S NAME First ISSAC Middle - Last HAWSE			15. MOTHER'S MAIDEN NAME First DORGES Middle - Last GLOVIER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		(If yes give war or dates of service) -		16b. SOCIAL SECURITY NO. 214-16-2033		17. INFORMANT Address 					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS RESPIRATORY FAILURE 4123 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY CONGESTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS 3 wks 5 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture, Right femur											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from MARCH 20, 1969 , to APRIL 2, 1969 , that (I) (we) last saw the deceased alive on APRIL 1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert F. Foddis MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/4/69			
22d. PHYSICIAN'S NAME (Type) ROBERT FODDIS				22e. ADDRESS 500 Truene St, Cumberland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4/4/69		23c. NAME OF CEMETERY OR CREMATORY Homewood Crematorium		23d. LOCATION (City or Town) (County) (State) Pittsburgh, Pennsylvania					
24. FUNERAL DIRECTOR John J. Hafer, Jr.				ADDRESS 230 Balto. Ave., Cumberland, Md.		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

04733

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04774		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04767					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR			
Rhoda			R.	McKenzie		4 Month 17 Day 69 Year		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		White		5/5/1889		19 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		U.S.A.				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Miners Hospital			House Work			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md			Allegany		Gilmore						
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Louis			Knippenburg			Susanna					Retalic
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no						Mrs. Raymond Robertson Gilmore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u>											
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u>										5 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Generalized Arteriosclerosis</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fracture left hip - 5 days prior</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>April 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
<u>Samuel J. Miles</u>							4.17.69				
22d. PHYSICIAN'S NAME (Type)		L.R. MILES, JR., M.D.			22e. ADDRESS						
					LONA CONING, MD. 21539						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)
Burial		4/19/69		Memorial Park			Frostburg		A.		Md
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George Eichhorn				Lonaconing, Md.				APR 18 1969			
								<u>Richard J. Judge</u>			

255-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 7-69

04775		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04768		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P
WILLIAM T. MC LUCKIE						APRIL 28, 1969		7:25
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		3-24-1893		78 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U. S. A.				ALLEGANY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			MEMORIAL HOSPITAL			RETIRED		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND		1814 FREDERICK ST.,	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
ANDREW MC LUCKIE						ALICE LARUE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
No			213-22-4290		MEMORIAL HOSPITAL, CUMB. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-renal failure</u>								
4123 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, generalized, with</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery disease</u>								
aging.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
<u>Chronic Prostatitis & Cystitis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If injury, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-27-1968</u> to <u>4-26-1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-26-1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.								
22b. SIGNATURE			22c. DATE SIGNED					
<u>Dr. W.F. Wms.</u>			<u>4-28-69</u>					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. CITY AND COUNTY		
DR. W.F. WMS.			21502			CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/30/69		Hillcrest Burial Park		Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service. Cumberland, Md			21502		MAY 2 1969		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 7-66

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Elmer Harley Miller						April Month 3 Day 1969		10a M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HOURS HOURS MIN.		
Male		White		June 29, 1909		59 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U.S.A.				Alleganey Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Westernport			111 Donna St.			Laborer		Paper Mill		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Alleganey		Westernport		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		111 Donna	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Howard R. Miller				Hazel Duckworth						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			217-05-0370		Ethel Miller Westernport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1570 Carinomatosis - liver & upper abdomen DUE TO, OR AS A CONSEQUENCE OF Carcinoma head of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
12 Nov 68		Whipple procedure			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
				April 3,						
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968, to July 1, 1969, that (I) (we) last saw the deceased alive on 1 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Norman J Reeves				M.D.				4 April 1969		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Norman J Reeves				M.D.		Westernport, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/6/69		Philos		Westernport Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Westernport, Md.				DATE APR 7 1969		Charles Judge				

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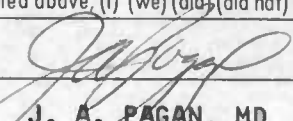

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

04777										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04770																																							
1. DECEASED-NAME (Type or print) First Middle Last FRANKLIN WILLIAM MILLER										2a. DATE OF DEATH 4 Month 9 Day 69 Year										2b. HOUR 10:30 PM																																							
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH 9-9-08										6. AGE (In years lost birthday) 60 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) W. VA.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.																			
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during usual work week, even if retired.) Machine Op.										12b. KIND OF BUSINESS INDUSTRY CELANESE										BUSINESS																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.										13b. COUNTY MINERAL										13c. CITY OR TOWN RIDGELEY										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 39 SECOND AVE.																			
14. FATHER'S NAME First Middle Last JOHN W. MILLER										15. MOTHER'S MAIDEN NAME First Middle Last (BAKER) ESSIE MILLER										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N NO										16b. SOCIAL SECURITY NO. 214-07-4609										17. INFORMANT HOSPITAL RECORDS										Address 900 SETON DR. CUMBERLAND, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Cecum										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 6 mos. 2 yrs.																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from March , 19 69 to April 9 , 19 69 , that (I) (we) last saw the deceased alive on April 9 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE 										DEGREE J. A. PAGAN, MD										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4-10-69																													
22d. PHYSICIAN'S NAME (Type) J. A. PAGAN, MD										22e. ADDRESS 1068 NATIONAL HWY., LA VALE, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4/12/69										23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Burial Park										23d. LOCATION (City or Town) (County) (State) nr. Cumberland, Allegany, Md.																													
24. FUNERAL DIRECTOR GEORGE'S FUNERAL HOME										ADDRESS GREENE ST. CUMBERLAND, MD.										25a. REC'D BY REGISTRAR APR 14 1969										25b. REGISTRAR'S SIGNATURE 																													

00330

10:30 89 9 4 MILLER W. J. FRANKLIN

WHITE 9--0 80

USA ; W. VA. ;

CUMBERLAND SACHED HIGHT HOSPITAL ALLEGANY COLLEGE

W. VA. INITIAL ETCLEY X 20 SECOND AVE.

W. J. HILLER (BANKER) ESSIE MILLER
X NO 214-07-400 HOSPITAL RECORDS CUMBERLAND, MD.
300 SECON W. HILLER

Information of ...
Geographical ...
Carolina of ...

At 11 9

100 NATIONAL H.Y., LA VALE, MD. J. A. FOGAR, ID

GEORGE'S FURNACE HOME GREENE ST. CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04778										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
William Howard Mintdrop						Apr. Month 4 Day 1969		8 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		March 11, 1895		74 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Md.		USA				Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			124 W. Oldtown Rd.			Crane Operator		Cement		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		124 W. Oldtown Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Criss Mintdrop			Gertrude Hughes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no					Mrs. Mae Mintdrop, Cumberland, Md. - Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Concurrent Heart Failure, Recurrent</i>										
4124 DUE TO, OR AS A CONSEQUENCE OF <i>Chronic stenosis, advanced</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <i>Chronic valvular disease, aortic</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>test</i> 19 <i>61</i> to <i>1968</i> that (I) (we) last saw the deceased alive on <i>1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>David T. Rees</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>Apr. 6, 1969</i>					
22d. PHYSICIAN'S NAME (Type) <i>Dr. David T. Rees, M.D.</i>					22e. ADDRESS <i>702 Montgomery Ave., Cumberland, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Apr. 7, 1969		Restlawn Mem. Gardens		La Vale, Md. Allegany				
24. FUNERAL DIRECTOR ADDRESS <i>James F. Scarpelli, Cumberland, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>APR 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William L. Under...</i>			

04771

Apr. 6, 1965

Mr. David T. Reed, Jr., 705 Montgomery Ave., Cumberland Md.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
WILLIAM			MORGAN			4/20			1969			12:30		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
MALE	WHITE	1/12/05	64	MONTHS	DAYS	HOURS	MIN.	4/20			12:30			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH								
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND			D.O.A. SACRED HEART HOSP.			COAL MINER			COAL MINES					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER (NATIONAL)					
MARYLAND			ALLEGANY			YES <input type="checkbox"/> NO <input type="checkbox"/>			R.F.D. 1, FROSTBURG, MD.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
WILLIAM			MORGAN			CARRIE			SPEIR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			BOX 264 MD.					
NO			N.A.			213-09-1905			MRS. WILLIAM MORGAN, R.F.D. 1, FROSTBURG,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												SUDDEN		
IMMEDIATE CAUSE (a) CORONARY OCCLUSION														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) CORONARY SCLEROSIS														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
				HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				4/20/69						
BENEDICT SKITARELIC, MD.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
BURIAL				4/22/69				FROSTBURG MEM. PARK FROSTBURG, ALLEGANY, MD.						
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG				DATE APR 24 1969				Charles Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 44-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE

100-100

100-100



100-100-100

100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
(BABY BOY)			MORRIS			APRIL 7 1969		3:29A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		APRIL 7, 1969		— YRS.		2 15	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		USA				ALLEGANY			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				16 VIRGINIA AVE.	
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
FRANCIS E. MORRIS				SHIRLEY C. HARPER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		none		MEMORIAL HOSP. CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Prematurity</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
<u>Dr. Nadeau</u>				DR. NADEAU M.D.		CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Apr. 8, 1969		St. Joseph's Cemetery		Midland, Md. Allegany			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.						APR 9 1969		<u>Charles Judge</u>	

04380

CENTRAL OF MARYLAND

1960	APRIL	MORRIS	(BABY BOY)	MALE	WHITE	APRIL 1, 1960	2	1
MEMORIAL HOSPITAL			USA	MARYLAND				
ALLGARY								
CUMBERLAND								
MARYLAND								
ALLGARY CUMBERLAND								
10 VIRGINIA AVE.								
FRANCIS E. MORRIS								
SHIRLEY C. HARPER								
MEMORIAL HOSP. CUMBERLAND, MD.								
none								

DR. HARRIS H.D. CUMBERLAND, MD.

James E. Scarpelli, Cumberland, Md.

Apr. 8, 1960 St. Joseph's Cemetery, Highland, Md. Allgans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>04781</div> <div>CERTIFICATE OF DEATH</div> <div>04774</div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
CLARICE S. MYERS						4 Month 8 Day 69 Year		3:40M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
FEMALE		WHITE		07 01 16		52 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. VA.		USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of work if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSPITAL			POST MISTRESS				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY		RAWLINGS				NONE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CHARLES SHOBE			MOLLIE HEDRICK SHOBE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO			217 07 4758		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-Carcinoma, Breast & Genovaryl Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>N/A</u>						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>N/A</u>		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-6</u> , 19 <u>69</u> , to <u>4-8</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>4-8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>William R. Wolverton</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/9/69</u>			
22d. PHYSICIAN'S NAME (Type) DR. WILLIAM R. WOLVERTON					22e. ADDRESS 955 FREDERICK STREET -CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/11/69		Hillcrest Burial Park		Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERVICE 404 DECATUR ST. CUMBERLAND, MD.					APR 14 1969		<u>Charles J. Judd</u>			

04781

CLAUDE	2	HYERS	4	69	3:1
WHITE	07 01 18	25			
XX					
USA					
ALLEGANY					
POST STREET					
SACRED HEART HOSPITAL					
MD.					
ALLEGANY					
RAMBLING					
SHORE					
CHARLES					
217 07 1251					
SACRED HEART HOSPITAL					
CONDELLAND, MD.					
000 SETON DRIVE					
HOLLY HENRICK SHORE					

DR. WILLIAM F. WILSON

922 FREDERICK STREET - CONDELLAND, MD.

WILSON-HENRICK FUNERAL SERVICE - 1011 1000

CONDELLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-69

04782		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04775	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
CLARA		A.		NILAND	4 Month 5 Day 69 Year		7:05A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
FEMALE		WHITE		4-20-75		93 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		U.S.A.				ALLEGANY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		Housewife		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		CUMBERLAND		724 NORTH CENTRE ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
PHILLIP				CLARKE	CATHERINE		SHANNON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>4409</u> <u>Wernia</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Infected Duodenal Ulcer</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 10</u> , 19 <u>69</u> , to <u>Apr 5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Apr 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Clayton Sumner</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/5/69</u>	
22d. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, <u>Burial</u> (Specify)		23b. DATE <u>Apr. 8, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04782

CLARA

A.

HILAND

FE ALE

WHITE

4-20-75

MARYLAND

M.S.A.

MARYLAND

CUMBERLAND

GEORGETOWN HOSPITAL

Houseside

MARYLAND

ALLEBANY

CUMBERLAND

724 NORTH CENTRE ST.

PHILLIP

CLARE

CATHERINE

MARYLAND, JO.
CUMBERLAND HOSPITAL

no

DR. CLAY BURRETT

CUMBERLAND, MD.

Enlist

Apr. 8, 1909

St. Patrick's Cemetery

Cumberland, Md.

James T. Correll, Cumberland, Md.

Apr. 8, 1909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
04783																		
04776																		
CERTIFICATE OF DEATH																		
1. DECEASED-NAME (Type or print)			First LEO			Middle JOSEPH			Last O'BAKER			2a. DATE OF DEATH APRIL Month 23 Day 1969			2b. HOUR 1:30 AM			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 11-17-98			6. AGE (In years last birthday) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) PA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DISABLED			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 402 WAVERLY TERRACE						
14. FATHER'S NAME First JOHN			Middle O'BAKER			Last NANCY			15. MOTHER'S MAIDEN NAME First NANCY			Middle ZORN			Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 220-10-2007			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA - METASTATIC - LIVER</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA - STOMACH</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 6 mos.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from _____, 1963, to APRIL 23, 1969, that (I) (we) last saw the deceased alive on APRIL 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>C. Bauer</u>			DEGREE DR. BAUER			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED APR. 26, 1969									
22d. PHYSICIAN'S NAME (Type) DR. BAUER			22e. ADDRESS CUMBERLAND, MD.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/25/1969			23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md									
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>			ADDRESS 230 Balto Ave. Cumberland			25a. REC'D BY REGISTRAR APR 28 1969			25b. REGISTRAR'S SIGNATURE <u>Charles E. Hafer</u>									

04788

DATE 11-11-53 TIME 11:30 AM

TO DIRECTOR, FBI

FROM SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

NY 100-100000

NY 100-100000

NY 100-100000

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04784

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04777

1. DECEASED-NAME (Type or Print)		First MARY		Middle A.		Last OFTEN		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> April 18 1969		2b. HOUR 3am		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH NOV. 19, 1905		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month April Day 18 Year 1969 8: a M		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY						
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R#2 Frostburg				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN ECKHART		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First JOHN Middle _____ Last ROSENBERGER				15. MOTHER'S MAIDEN NAME First _____ Middle GRACE Last LARUE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-32-8338		17. INFORMANT ADDRESS EMORY ROSENBERGER, RT. 2, FROSTBURG, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ---		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED April 18, 1969 ADDRESS (Street, city, town, or county) Cumberland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK				23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.				
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD.						ADDRESS 21532		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

38788

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
HONOLULU, TERRITORY OF HAWAII

NAME		DATE	
SEX		AGE	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		RESIDENCE	
BIRTH		DEATH	
CAUSE		MANNER	
PLACE		CITY	
COUNTRY		STATE	
HOSPITAL		CLINIC	
PHYSICIAN		NURSE	
FAMILY		FRIENDS	
RELATIVES		OTHER	
SIGNATURE		DATE	
OFFICIAL		OFFICE	
TITLE		ADDRESS	
CITY		STATE	
COUNTRY		POSTAL	
TELEPHONE		FAX	
E-MAIL		WEBSITE	
GEOGRAPHIC		CLIMATE	
ECONOMIC		SOCIAL	
CULTURAL		HISTORICAL	
LITERARY		ARTS	
SCIENCE		TECHNOLOGY	
ENVIRONMENT		NATURE	
WATER		AIR	
LAND		SPACE	
TIME		MATTER	
ENERGY		FORCE	
MOTION		CHANGE	
LIFE		DEATH	
HEALTH		DISEASE	
MIND		BODY	
SPIRIT		SOUL	
HEAVEN		HELL	
PARADISE		PURGATORY	
HEAVENLY		EARTHLY	
DIVINE		HUMAN	
ANGELIC		DIABOLIC	
SACRED		PROFANE	
BLESSED		CURSED	
HOLY		UNHOLY	
PURE		IMPURE	
GOOD		EVIL	
VIRTUE		VICE	
WISDOM		FOOLISHNESS	
KNOWLEDGE		IGNORANCE	
TRUTH		LIE	
JUSTICE		INJUSTICE	
MERCY		CRAUELTY	
GENTLENESS		RAGE	
PATIENCE		IMPATIENCE	
KINDNESS		UNKINDNESS	
LOVE		HATE	
HOPE		DESPAIR	
FAITH		DUBIETY	
CHARITY		SELFISHNESS	
GOD		DEVIL	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
CHARITIES		SELFISHNESSES	
GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
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GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
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HEAVENLYS		EARTHLYS	
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SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
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BLESSEDS		CURSEDS	
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VIRTUES		VICES	
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TRUTHS		LIES	
JUSTICES		INJUSTICES	
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GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
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GODS		DEVILS	
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BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
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JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
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BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
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HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
CHARITIES		SELFISHNESSES	
GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
CHARITIES		SELFISHNESSES	
GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
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PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
CHARITIES		SELFISHNESSES	
GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
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DIVINES		HUMANES	
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BLESSEDS		CURSEDS	
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WISDOMS		FOOLISHNESSES	
KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
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GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
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GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISES		PURGATORIES	
HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
GOODS		EVILS	
VIRTUES		VICES	
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KNOWLEDGES		IGNORANCES	
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PATIENCES		IMPATIENCES	
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HEAVENLYS		EARTHLYS	
DIVINES		HUMANES	
ANGELICS		DIABOLICS	
SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
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VIRTUES		VICES	
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KNOWLEDGES		IGNORANCES	
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JUSTICES		INJUSTICES	
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GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
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HOPES		DESPAIRS	
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DIVINES		HUMANES	
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SACREDS		PROFANES	
BLESSEDS		CURSEDS	
HOLYS		UNHOLYS	
PURES		IMPURES	
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SPIRITS		GHOSTS	
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HEAVENS		EARTHS	
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ANGELICS		DIABOLICS	
SACREDS		PROFANES	
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KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
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KNOWLEDGES		IGNORANCES	
TRUTHS		LIES	
JUSTICES		INJUSTICES	
MERCYS		CRAUELITIES	
GENTLENESSES		RAGES	
PATIENCES		IMPATIENCES	
KINDNESSES		UNKINDNESSES	
LOVES		HATES	
HOPES		DESPAIRS	
FAITHS		DUBIETIES	
CHARITIES		SELFISHNESSES	
GODS		DEVILS	
ANGELS		DEVILS	
SPIRITS		GHOSTS	
SOULS		BODIES	
HEAVENS		EARTHS	
PARADISE			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04785

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04778

1. DECEASED-NAME (Type or Print) FRANK JOSEPH O'GRINCE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month APRIL Day 10 Year 1969			2b. HOUR 9:30 P M			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH FEB. 13, 1933	6. AGE (In years last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month APRIL Day 10 Year 1969			2d. HOUR 9:30 P M
7a. BIRTHPLACE (State or foreign country) ECKHART, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL--DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY CEMENT FACT.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE OHIO		13b. COUNTY PORTAGE		13c. CITY OR TOWN RAVENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Oaks R.F.D. 5, Trailer Court	
14. FATHER'S NAME First LOUIS Middle O'GRINCE Last FRANCES			15. MOTHER'S MAIDEN NAME First BODLINGER Middle FRANCES Last BODLINGER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			
16b. SOCIAL SECURITY NO. KOREA 220-32-4092			17. INFORMANT FROSTBURG, MD. 21532 MR. LOUIS O'GRINCE, 130 CENTRE ST.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS, LEFT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY SCLEROSIS (b) -- DUE TO, OR AS A CONSEQUENCE OF (c) --									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelis			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			APRIL 10, 1969			
ADDRESS (Street, city, town, county, state) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY ST. ANN'S CEMETERY			23d. LOCATION (City or Town) (County) (State) GARRETT, MD.		
24. FUNERAL DIRECTOR MARILOU M. SOWERS-HAFER-SOWERS				ADDRESS HOME, 60 W. MAIN, FROSTBURG			25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge

28540

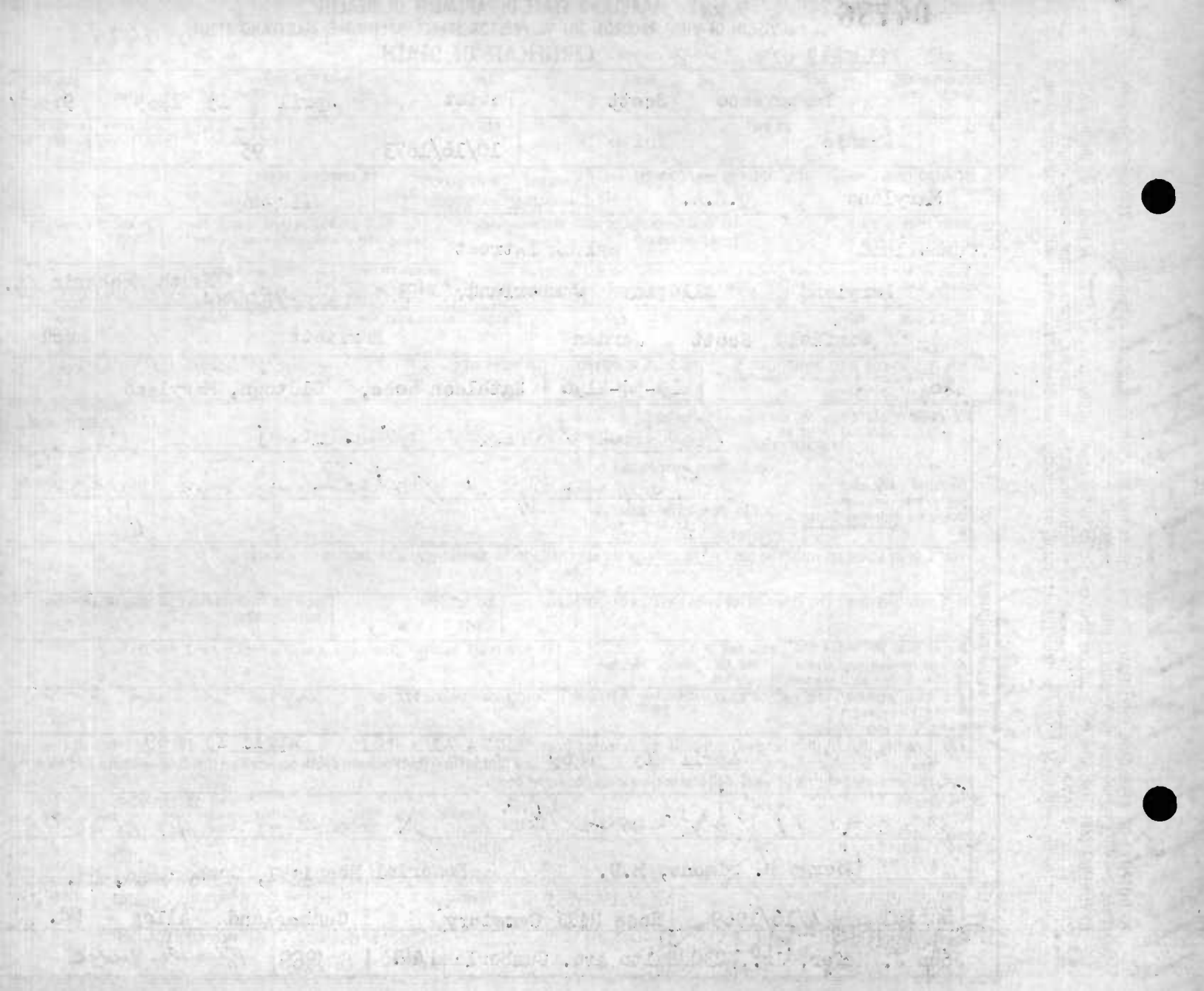
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1004-5506-03

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 412 4/30/69 kk		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04779	
1. DECEASED-NAME (Type or print) First Middle Last Temperence Scott Pettet			2a. DATE OF DEATH April Month 13 Day 1969 Year		2b. HOUR 9:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10/16/1873		6. AGE (In years last birthday) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Unknown North Mechanic St.
14. FATHER'S NAME First Middle Last Winfield Scott Jordan			15. MOTHER'S MAIDEN NAME First Middle Last Harriett Shuck		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, No		16b. SOCIAL SECURITY NO. 219-54-2196	17. INFORMANT Address Kathleen Hose, Oldtown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ypn</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15, 1967</u> , to <u>April 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George M. Simons, M.D.</u>		22c. DATE SIGNED <u>4/15/69</u>		22d. PHYSICIAN'S NAME (Type) George M. Simons, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/1969		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr., 230 Balto Ave. Cumberland</u>		25a. REC'D BY REGISTRAR DATE <u>APR 16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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VR A15
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
04787		CERTIFICATE OF DEATH						04780				
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
IRENE			B		REITH				4 Month 3 Day 69 Year		12:10 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE			WHITE			6-1-04			64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
MARYLAND			U.S.A.						ALLEGANY Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			MEMORIAL HOSPITAL			Housewife			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY			CUMBERLAND			YES		339 BEDFORD ST.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
CONRAD			HERPICH			Maggie			M Wiebel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			None			MEMORIAL HOSPITAL			CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Septicemic Sepsis</u>										6 mos		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <u>7341</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
						Cumberland Allegany Md						
22a. I certify that (I) (this hospital) attended the deceased from <u>3/27/69</u> 19, to <u>4/3/69</u> 19, that (I) (we) last saw the deceased alive on <u>4/3/69</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			22e. DATE SIGNED			
<u>Dr. R. J. Williams</u>			DR. R. J. WILLIAMS			CUMBERLAND, MD.			4/4/69			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4/7/69			Hillcrest Burial Park			Cumberland Allegany Md			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
William G. Kight			Cumberland, Md.			APR 8 1969			<u>Charles Judge</u>			

04787

IRENE	B	REITH	3	02 12:10P
PE WLE	WHITE	0-1-04	04	
MARYLAND	U.S.A.	X		ALLGANY
CUMBERLAND	MEMORIAL HOSPITAL	HOSPITAL		OWN HOME
MARYLAND	ALLEGANY	CUMBERLAND	NO	330 EEDFORD ST.
CONRAD	BERNICH	Maggie	H	Widow
NO	None	MEMORIAL HOSPITAL	CUMBERLAND, MD.	

William O. Riggs
Cumberland, Md. 1902
Burial 4/1/02
Burial 4/1/02
Cumberland, Md. 1902
Burial 4/1/02
Cumberland, Md. 1902

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last WALTER ELWOOD RITCHIE					2a. DATE OF DEATH Month Day Year APRIL 16 1969		2b. HOUR 4:40A		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-5-11		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and house no.) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine op.		12b. KIND OF BUSINESS OR INDUSTRY Celanece			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11 N. LEE ST.	
14. FATHER'S NAME First Middle Last IRVIN J. RITCHIE		15. MOTHER'S MAIDEN NAME First Middle Last BERTHA C. TEETS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 217-10-5540		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Obstruction of Left Anterior Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis + Myocardial Hypertrophy</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 4 hrs —
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> , 19 <u>69</u> , to <u>4/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George M. Simons</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/16/69</u>		
22d. PHYSICIAN'S NAME (Type) George M. Simons, M. D.					22e. ADDRESS Memorial Hosp. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Md.					25a. REC'D BY REGISTRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

04788

WALTER ELWOOD RITCHIE APRIL 18 1959 4:40P

MALE WHITE 75-11
PA. USA ALLEMAN

CUMBERLAND MEMORIAL HOSPITAL MEDICAL DEPT. CUMBERLAND

ALLEGANY CUMBERLAND X 11 W. LEE ST.

IRVIN J. RITCHIE BERTHA G. (TEETS)

117-10-2540 MEMORIAL HOSPITAL, CUMBERLAND, MD.

George H. Simon, M.D. Memorial Hosp. Cumberland, Md.

H. Wayne George Cumberland, Md. 11/18/54
Source: Memorial Hosp. Cumberland, Allegany Md.
4/20/59

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04789

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04782

1. DECEASED-NAME (Type or Print)			First De Coursey			Middle A.			Last Roth			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Apr. 26 19 69			2b. HOUR 11A 30 M				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH Feb. 14, 1896		6. AGE (in years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Apr. Day 26 Year 1969			2d. HOUR 11A 30 M				
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.							
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. Memorial H. Retired Carman								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Railroad				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9 Long Drive					
14. FATHER'S NAME First David O. Middle Roth Last						15. MOTHER'S MAIDEN NAME First Margaret L. Middle Weber Last													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes						16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) War I-Marines						17. INFORMANT ADDRESS Mrs. Mabel Roth, Cumberland, Md.-Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) --												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Benedict Skitarelic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED April 26, 1969							
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.						ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Apr. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.									
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						ADDRESS				25a. REC'D BY REGISTRAR DATE APR 29 1969				25b. REGISTRAR'S SIGNATURE William J. Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04790									
CERTIFICATE OF DEATH									
04783									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Leo			Stuart			April 2, 1969			12:20
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
Male		White		10/19/81			87 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Md.		U.S.A.					Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Sylvan Retreat			Painter			Self emp.
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Allegany			Lonaconing			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Patrick Rowan			Anna Barkely						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			210-10-5955		Lillian Kiddy Lonaconing, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ym</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15, 19 67</u> , to <u>April 2, 19 69</u> , that (I) (we) last saw the deceased alive on <u>April 1, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George M. Simons</u>					22c. DATE SIGNED <u>4/4/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>George M. Simons</u>					22e. ADDRESS <u>Memorial Hospital, Cumberland, Md. 21502</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/5/69		Oakhill		Lonaconing		Md.	
24. FUNERAL DIRECTOR <u>E. P. Bual</u>					25a. REC'D BY REGISTRAR <u>DA APR 8 1969</u>		25b. REGISTRAR'S SIGNATURE <u>O. C. Oudea</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04791

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04784

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Harry Francis Ruby						April 7, 1969			11A					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	March 1, 1887	82 YRS	MONTHS	DAYS	HOURS	MIN.	April 7, 1969			11:00 AM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		U.S.A.				Allegany								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
R 9, Cumberland			R 9 Baltimore Pike (DOA)			Roads Supervisor			County Roads					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland			Allegany		Flintstone		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #2					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
John Ruby			Catherine Imes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No			214-36-7077		Grant L. Ruby, Rt. #2, Flintstone, Md. (Son)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) CORONARY OCCLUSION												Sudden		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) CORONARY SCLEROSIS														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. P.M.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			April 7, 1969					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			Cumberland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			4/9/69		Beans Cove Methodist Cem.			Beans Cove, Bedford, Penna.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Charles E. Hafer			230 Balto. Ave., Cumberland, Md.			APR 9 1969			[Signature]					

04701

RESEARCH & TECHNICAL DEPT.

Barry
March 1, 1947
U.S.A.
Albany
County, New York
Albany
County, New York
Albany
County, New York

21-00-000
COUNTY COMMISSION
COUNTY COMMISSION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04792		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04785	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
JOHN		J.	SCHLERETH		Month Day Year 4 24 69		2:25PM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-17-08		6. AGE (In years last birthday) 60 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Celanese Textile	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 554 WINIFRED RD, X		14. FATHER'S NAME First Middle Last AUGUST SCHLERETH		15. MOTHER'S MAIDEN NAME First Middle Last MARY GALSTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure, Rt & left</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>due to Myocardial Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Previous Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 year 15 year 15 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary thrombosis Arteriosclerosis of Heart Muscles</u> 15 year 2 year							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> , 19 <u>69</u> , to <u>4/24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. S. G. Weisman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/25/69	
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 4-28-1969		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

04592

JOHN	MALE	HEMMIX WHITE	6-17-08	SCOTTISH
U.S.A.	WAB LAND	ALLEGANY	80	ALLEGANY
CUMBERLAND	ALLEGANY	NEURAL HOSPITAL	NEURAL HOSPITAL	NEURAL HOSPITAL
MARYLAND	ALLEGANY	CUMBERLAND	CUMBERLAND	CUMBERLAND
AUGUST	SCOTTISH	MARY	BARSTEN	CUMBERLAND, MD.

DR. S. B. WEISMAN CUMBERLAND, MD.

James Y. Scribner, Cumberland, Md.
 4-28-1962 St. Mary's Cemetery
 Cumberland, Allegany, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04793									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Mary Lillian Schurg					2a. DATE OF DEATH at 3:50 P.M. April 5, 1969		2b. HOUR P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/6/1903		6. AGE (In years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Centenial Street	
14. FATHER'S NAME First Middle Last William Bishop			15. MOTHER'S MAIDEN NAME First Middle Last Rose Winebrenner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-10-6806D		17. INFORMANT P. O. Box 599, Cumberland, Md. Allegany County Infirmary records.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Disease DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 342X APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx. 10 days many years many years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) old C.V.A. & repaired aneurysm									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 22, 1964 , to April 5, 1969 , that (I) (we) lost saw the deceased alive on April 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Tappan					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 7-1969		
22d. PHYSICIAN'S NAME (Type) John A. Tappan					22e. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-69		23c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		23d. LOCATION (City or Town) (County) (State) Bittinger, Garrett, Md.			
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532					25a. REC'D BY REGISTRAR APR 9 1969				

04703

EXHIBIT OF DEED

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Edna Irene Shipley						ESTIMATED <input checked="" type="checkbox"/> Month Day Year			7:45 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	3/8/1898	71 YRS.					Month Day Year	9:45 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U S A				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Little Orleans			At Home-Little Orleans Md			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Allegany		Little Orleans				----
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Sowers			Elmira Bennett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No						Marie Teeter, Route 2, Flintstone, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN --	
CORONARY OCCLUSION									
CORONARY SCLEROSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 3, 1969			
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Apr. 5, 1969		Fairview Christian Cem		Near Artemas Bedford Penna			
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Hafer, Jr. 230 Balto Ave. Cumberland Md						APR 7 1969		<u>Charles Judge</u>	

20520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M 1/69

04795		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04788	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First GLENN A		Middle JUNE		Last SMITH	
2a. DATE OF DEATH		Month APRIL		Day 29		Year 1969	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-27-31		6. AGE (In years last birthday) 37 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME		First GEORGE S		Middle MCDONALD		Last ERMA E. ATHEY	
15. MOTHER'S MAIDEN NAME		First ERMA		Middle E.		Last ATHEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-28-7598		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute cardiac failure & anasarca 6 days</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>(?) Radiation myocarditis & pulm. ? mo.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Treatment for bilat Breast Ca 2 1/2 yrs.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 2/24/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilat. Breast Ca		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Mirkin MD</i>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) DR. MIRKIN		22e. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 5/1/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service, Cumberland, Md		ADDRESS 21502		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

04795

FEDERAL BUREAU OF INVESTIGATION

APRIL 27 1963 2:00 PM

10-2-31

WHITE

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MARYLAND

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CONSUMPTION

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210-1-1-1 HOSPITAL, COMMERCIAL, E.

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DR. HIRSH

FEDERAL BUREAU OF INVESTIGATION

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210-1-1-1 HOSPITAL, COMMERCIAL, E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 24 Film 412 5/5/69 gk & Items 5, 7, 23												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
04796												
CERTIFICATE OF DEATH												
04789												
1. DECEASED-NAME (Type or print) First Middle Last PHILIP D SMITH						2a. DATE OF DEATH Month Day Year APRIL 17 1969			2b. HOUR 5:40 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH July 21, 1900		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penna. W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.				13b. COUNTY VA.		13c. CITY OR TOWN PAW PAW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Branch</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ext Sch C.D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State <i>Cumberland, Pa.</i>								
22a. I certify that (I) (this hospital) attended the deceased from 4/16/69, 19, to 4/17/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>R. J. Williams</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/25/69				
22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS						22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/20/1969		23c. NAME OF CEMETERY OR CREMATORY Camp Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Paw Paw Morgan W. Va.						
24. FUNERAL DIRECTOR ADDRESS Johnson Funeral Home - Paw Paw, West Virginia						25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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ALLEGANT

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MEMORIAL HOSPITAL

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W. VA.

MEMORIAL HOSPITAL, CHURCHLAND, W. VA.

DR. R. J. WILLIAMS

123 ST. CENTRE ST., CHURCHLAND, W. VA.

APR 28 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

04797												MARYLAND STATE DEPARTMENT OF HEALTH												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												04790											
1. DECEASED-NAME (Type or print) First Middle Last WALTER THOMAS SMITH												2a. DATE OF DEATH Month Day Year APRIL 8, 1969												2b. HOUR PM 10:55																							
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH 1-5-14				6. AGE (In years lost birthday) YRS. 55				IF UNDER 1 YEAR MONTHS				IF UNDER 24 HRS. HOURS MIN.																											
7a. BIRTHPLACE (State or foreign country) MARYLAND, Barton				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.																																			
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED TECH.				12b. KIND OF BUSINESS OR INDUSTRY Rocket Plant																																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CRESAPTOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER RT. #6 REDWOOD ST.																															
14. FATHER'S NAME First Middle Last THOMAS SMITH				15. MOTHER'S MAIDEN NAME First Middle Last ANNIE LYONS																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 213-03-4740				17. INFORMANT SACRED HEART HOSPITAL PTS. CHART				Address 900 SETON DRIVE CUMBERLAND, MD. 21502																																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 481X IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days																																			
												PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from March, 19 69 , to April 8 19 69 , that (I) (we) last saw the deceased alive on April 8 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 4-10-69																																			
22d. PHYSICIAN'S NAME (Type) JA. PAGAN, M.D.				22e. ADDRESS 1068 NATL HWY., LA VALE, CUMB., MD. 21502																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/12/69				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																																			
24. FUNERAL DIRECTOR GEORGE FUNERAL HOME				ADDRESS 202 GREENE ST CUMBERLAND, MD. 21502				25a. REC'D BY REGISTRAR APR 14 1969				25b. REGISTRAR'S SIGNATURE 																																			

GEORGE FUNERAL HOME
CUMMINGS, N. 21205
SOS GREENE ST.

TO: BACON, N. J.
1008 N. W. H. Y. LA VLE, CUMMINGS, N. 21205

APR 11 1963
SACRED HEART HOSPITAL
CUMMINGS, N. 21205

APR 11 1963
SACRED HEART HOSPITAL
CUMMINGS, N. 21205

APR 11 1963
SACRED HEART HOSPITAL
CUMMINGS, N. 21205

APR 11 1963
SACRED HEART HOSPITAL
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CUMMINGS, N. 21205

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04798

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04791

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Louis C. Soethe					April 2, 1969					9:05 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	Sept 3, 1922		46 YRS.	MONTHS		DAYS		April 2, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		9:05 PM		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital-DOA		Sales Representat.		Food				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		672 Fayette St.		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
William Louis Soethe					Mary Brookman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		213-12-9985		Mrs. Marian Soethe, Cumberland, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED APRIL 2, 1969
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ADDRESS (Street, city, town, or county) Cumberland, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/7/69		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.				
24. FUNERAL DIRECTOR William G. Kight		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

04733

Half White 2002 3, 1941 5
Allegany 021
Memorial Hospital - Dr. James Robertson, Wood
Allegany Cumberland X 372 Kayette St.

William Louis Soethe Mary Soethe
213-12-9885 Mr. Marian Soethe, Cumberland, Md.
Soethe

Coronary Occlusion
Coronary Thrombosis
Coronary Sclerosis

St. Peter's Hospital, Cumberland, Md.
Cumberland, Md. 21502
Benedict Smith, R.D.
G. Knight
21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First MARY Middle I. Last SOLOMON			2a. DATE OF DEATH		2b. HOUR			
						APRIL Month 25 Day 69 Year		8:10 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
FEMALE		WHITE		9-22-80		88 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WEST VA.		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city)			12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND, MD.			SACRED HEART HOSPITAL			NWP		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		FROSTBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT. #2 BOX 86		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First JOHN Middle W. Last CALHOUN			First SARAH Middle FRANCES Last NAIR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT						
NO			None		PTS CHART						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Uremia - nephrosclerotic type</u>											
4123 DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Heart Disease - arteriosclerotic</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>Pulmonary Edema</u> <u>Brain Ischemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , to <u>4/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>S.G. Weisman</u>									<u>4/25/69</u>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
S.G. WEISMAN, M.D.					59 GREENE ST., CUMB., MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		4/27/69		PORTER CEMETERY		ECKHART,		ALLEGANY,		MD.	
24. FUNERAL DIRECTOR		60 ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Marlow M. Sowers</u>		<u>60 MAIN ST.,</u>		DATE		<u>APR 29 1969</u>		<u>Charles Judge</u>			
HAFFER-SOWERS FUNERAL HOME		FROSTBURG									

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MAY 1 1952 APRIL 25 1952

WHITE 9-22-50

WEST VIR. ALLEGANY

CHURCHLAND, INC. SACRED HEART HOSPITAL HMF HOME

MARYLAND ALLEGANY FROSTBURG X LT. 42 BOX 20

JOHN W. CALHOUN SALVA

21502 SACRED HEART HOSPITAL CHURCHLAND, INC. LT. CHART

20 GREENE ST., CUMBERLAND, MD. 21502 S.C. WEISMAN, INC.

HAFFER-SIMONS FUNERAL HOME, 1527 G ST. N.E. WASHINGTON, D.C. 20002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04800									
CERTIFICATE OF DEATH									
04793									
1. DECEASED-NAME (Type or print) First Middle Last HUGH M. TERNENT					2a. DATE OF DEATH April Month 6 Day 1969			2b. HOUR 9A. M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/20/1913		6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany		Md.	
10. CITY OR TOWN OF DEATH Lonaconing		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Scotch Hill		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Luke Paper Mill		12b. KIND OF BUSINESS OR INDUSTRY Paper			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Scotch Hill	
14. FATHER'S NAME First Middle Last Willial J. Ternent				15. MOTHER'S MAIDEN NAME First Middle Last Barbara McMillian					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 220-10-1775		17. INFORMANT Address Thelma Ternent, Lonaconing, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3949 IMMEDIATE CAUSE (a) Coronary Occlusion (WIFE) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) open mitral stenosis Cleveland Clinic 2 mos - DUE TO, OR AS A CONSEQUENCE OF (c) H.C.U.D. Years.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1968, to April 6, 1969, that (I) (we) last saw the deceased alive on 4/5/69-19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Davis, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/7/69-					
22d. PHYSICIAN'S NAME (Type) John B. Davis, M.D.				22e. ADDRESS 2 Broadway, Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April, 9, 98		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.			
24. FUNERAL DIRECTOR GEORGE EICHHORN				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04801		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04794	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) Walter Clark Uhl		2a. DATE OF DEATH April Month 21 Day 1969		2b. HOUR 11:55 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 22, 1912		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany	
10. CITY OR TOWN OF DEATH Westernport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 207 Central Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor		12b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Edgar Middle Uhl Last Clark		15. MOTHER'S MAIDEN NAME First Bertha Middle Clark Last Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service) WW 2		16b. SOCIAL SECURITY NO. 216 07 9649		17. INFORMANT Ester Uhl		Address Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Carcinoma Left Lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 7, 1969 , to April 21, 1969 , that (I) (we) lost saw the deceased alive on April 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Robert W. Bess Jr.				22c. DATE SIGNED April 22, 1969			
22d. PHYSICIAN'S NAME (Type) Robert W. Bess Jr.				22e. ADDRESS Piedmont, W. Va.			
23a. BURIAL, CREMATION, BURIED (Specify)		23b. DATE 4/24/69		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION (City or Town) (County) (State) Westernport, Md. Allegany	
24. FUNERAL DIRECTOR E.S. Boal				25a. REC'D BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

30820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04802		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04795		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)		First RUSSELL		Middle P.	Last WALTERS	2a. DATE OF DEATH APRIL Month 16 Day 1969		2b. HOUR 2:10A
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 4-12-96		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and house no.) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Tire Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY Bedford Co.		13c. CITY OR TOWN CLEARVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1
14. FATHER'S NAME First HEZEKIAH		Middle WALTERS		Last RACHEL		15. MOTHER'S MAIDEN NAME First WILKINSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown No		16b. SOCIAL SECURITY NO. 170-12-3952		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholera</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cholera + cholera</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cholera</u> 5741 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 days 25 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Des Myocardial infarction - Atherosclerotic Heart Disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sum</u> , 19 <u>67</u> , to <u>4/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. Weisman</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/16/69		
22d. PHYSICIAN'S NAME (Type) DR. WEISMAN		22e. ADDRESS CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/69		23c. NAME OF CEMETERY OR CREMATORY Chaneyville MethCem, Bedford Co., Pa.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR CONNER FUNERAL HOME EVERETT, PA.		ADDRESS		25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

04803

NAME WHITE 4-13-90 73
RUSSELL F. WALTERS
APRIL 10 1990 2:10A

CUMBERLAND PENNA. USA
MEMORIAL HOSPITAL Lebanon
PENNA. Bedford Co. CLEARVILLE
ROUTE 1
HESTERIAN WALTERS RACHAL WILKINSON
170-12-3982 MEMORIAL HOSPITAL CUMBERLAND, MD.

DR. WEISMAN CUMBERLAND, MD.

COOPER FUNERAL HOME EVERETT, PA.
4/13/90
CHANEYSVILLE METHODIST BEDFORD CO. PA.
APR 11 1990

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04803

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04796

1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR				
Marie Elizabeth Weaver						April 13, 1969			2:37M				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
Female	White	3/ 1/1906	63 YRS.					April 13, 1969			2:37M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			U S A						Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Sacred Heart Hospital			Grocery Clerk-Retired			Hartman's Gr				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1, Bowman's Addition	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost										
John Thomas			Margaret Williams										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			218-24-7929			Irvin Thomas			16 Balto St. Cumberland, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, RIGHT 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				APRIL 13, 1969					
				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			4/16/1969			Frostburg Memorial Park			Frostburg, Alleg Md.				
24. FUNERAL DIRECTOR <u>John J. Hefer, Jr.</u> ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John J. Hefer, Jr. 230 Balto Ave. Cumberland						DATE APR 16 1969			<u>William J. Judge</u>				

04703

ATTEST: I HAVE EXAMINED THE RECORDS OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04804		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		04797			
1. DECEASED-NAME (Type or print) HENRY			First Middle Last Clay WHITE		2a. DATE OF DEATH Month 4 Day 12 Year 69			7. HOUR 7:45 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8-5-1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY Brewery			Md
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CRESAPTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Valley View Dr. RT. #5, BOX 162	
14. FATHER'S NAME First Middle Last MADISON WHITE			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH (WHITE)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced metastatic carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) of prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/8 - 4/12									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/8/1969 , to 4/12/1969 , that (I) (we) last saw the deceased alive on 4/11/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Walter N. Himmler MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69			
22d. PHYSICIAN'S NAME (Type) DR. WALTER N. HIMMLER		22e. ADDRESS 412 N. MECHANIC ST., CUMBERLAND,							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.		Md	
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS Cumberland, Maryland		25a. REC'D. BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE H. Wayne George	

06804

HENRY

CLAY

WHITE

12

80

U.S. 1888

WHITE

WAGE

ALLEANY

U.S.A.

W. VA.

CUMBERLAND

MEMORIAL HOSPITAL LABORER

MARYLAND

ALLEANY

CREATION X

RT. 65

BOX 102

WHITE

HAUSON

ELIZABETH

(WHITE)

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1900

for additional information

1900

DR. WALTER R. MILLER

112 N. MICHIGAN ST., CUMBERLAND

4/15/88

CONFIDENTIAL

U.S. Marine Corps, Maryland

APR 15 1988

CUMBERLAND, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04805				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04798			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
Bessie Whiteman				4 Month 14 Day 69 Year				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		12/10/1911		57 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Md		U.S.A.				Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Lonaconing (Rural)				House Work		Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET AND NUMBER					
Md		Allegany		Lonaconing							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
William Goodwin		Hattie Waxler		no				Lloyd Whiteman		Shaft, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Coronary Artery Disease</u>										2 years	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Generalized Arteriosclerosis</u>										years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Obesity - Schizophrenia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>56</u> to <u>April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>L.R. Miles</u> MD		4.15.69		L.R. MILES, JR		LONA CONING MD 21539					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/17/69		Greens Cemetery		Garrett		Md			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George Eichhorn				Lonaconing, Md.				APR 17 1969			

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

John D. Long

Secretary

U. S. Department of Agriculture

Washington, D. C.

Enclosed for you are two copies of a report of the

Commissioner of the General Land Office, dated December 15, 1899,

relating to the proposed sale of certain public lands in the State of

California.

I am, Sir, very respectfully,

Yours very truly,

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 4
45M - 11/69

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
04806																			
04799																			
1. DECEASED-NAME (Type or print)			First ROSEMARY			Middle E.			Last WILHELM			2a. DATE OF DEATH Month 4 Day 1 Year 69			4:11:21 P.M.				
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 8-9-1913			6. AGE (In years last birthday) 55			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY										
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG, MD.			13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>			13e. STREET AND NUMBER 124 WASHINGTON ST.,							
14. FATHER'S NAME First EARL			Middle PURBAUGH			Last TERESA			15. MOTHER'S MAIDEN NAME First TERESA			Middle COLLINS			Last COLLINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-07-2437			17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			Address										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Walled arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pronounced cerebral</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Anemia</u>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>3-22-1969</u> to <u>4-1-1969</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3-30-1969</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.																			
22b. SIGNATURE <u>Wm. F. Williams</u>			22c. DATE SIGNED 4-3-69			22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-4-69			23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.										
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532			25a. REC'D BY REGISTRAR DATE APR 7 1969			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>													

02808

CERTIFICATE OF DEATH

ROSEMARY

WILHELM

FEARLE

WHITE

8-9-1913

MARYLAND

U. S. A.

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

MARYLAND

ALLEGANY PROCTOR B. RD.

124 WASHINGTON ST.

EARL

BOURBON

TERESA

COLLINS

STAY-OUT

MEMORIAL HOSPITAL CUMBERLAND, MD.

DR. W. F. WILLIAMS

122 S. CENTRE ST., CUMBERLAND, MD.

APR 7 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle-	Lost	2a. DATE OF DEATH			2b. HOUR
Bertha			M.		WILKENS	APRIL 14 1969			4:47 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
female		White		11-21-97		71 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Cumberland Nursing Centre of Clerking-Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Allegany		Cumberland				1303 Bedford Street	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Newton			M		Carder	Clara			E O'NEIL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
NO			211-05-6449			MRS. Audrey Leasure - Cumb. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinomatous, generalized</u>									Jan. 69
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>adeno-carcinoma stomach</u>									Nov. 68?
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1/17/69		Adenocarcinoma, cardia & lesser curvature, stomach.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>8 November, 1968</u> , to <u>14 Apr., 1969</u> , that (I) (two) last saw the deceased alive on <u>12 Jan., 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (two) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
W. A. Van Ormer, M.D.						<input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DR. Van Ormer M.D.				122 S. Centre Street, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		4/16/69		Hillcrest Burial Park		Cumberland		Allegany	Maryland
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service, Cumberland, Md.				21502		APR 18 1969		Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

04808		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04801			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month 4 Day 23 Year 69		9:30 A.M.	
LONNIE		RAYMOND		WINEBRENNER					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		8-13-1898		70		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
MARYLAND		U. S. A.				ALLEGANY		CUMBERLAND	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET AND NUMBER		13b. CITY OR TOWN	
MEMORIAL HOSPITAL		CA worker		Japanese Silk		Wright's Lane		CUMBERLAND	
13c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13d. COUNTY		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET AND NUMBER		13g. CITY OR TOWN	
MARYLAND		ALLEGANY				BOWLING GREEN		CUMBERLAND	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First		Middle		Last		First		Middle	
WILLIAM		S.		WINEBRENNER		SUSAN		Hutzel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Congestive heart failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) basis of far advanced A.D.C. D. Dis.									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Emphysema & pulmonary fibrosis									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-10-1969, to 4-23-1969, that (I) (we) lost saw the deceased alive on 4-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. F. Williams		22c. DATE SIGNED 4-24-69		22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/26/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE APR 28 1969			
Cumberland, Md.									

04808

CERTIFICATE OF DEATH

NAME: MALE
RACE: WHITE
DATE OF BIRTH: 8-13-1898
PLACE OF BIRTH: ALLEGANY
OCCUPATION: U. S. A.
CAUSE OF DEATH: K
DATE OF DEATH: 23 OF 1930

PLACE OF DEATH: GUMBERLAND
HOSPITAL: MEMORIAL HOSPITAL, CA
CITY: ALLEGANY
COUNTY: GUMBERLAND
STATE: ALLEGANY
DECEASED: WILLIAM S. WINGBURNER
SUSAN
514-07-2834 MEMORIAL HOSPITAL-GUMBERLAND, MD.

[Faint, illegible handwritten text]

DR. W. F. WILLIAMS
122 S. CENTRE ST., GUMBERLAND, MD.
4/26/32
GUMBERLAND, ALLEGANY, MD.
FEB 2 2 1932